

120.6

**ARTICLE 3**

120.7

**KEEPING NURSES AT THE BEDSIDE**

120.8 Section 1. Minnesota Statutes 2022, section 144.1501, subdivision 1, is amended to read:

120.9 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
120.10 apply.

120.11 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist  
120.12 under section 150A.06, and who is certified as an advanced dental therapist under section  
120.13 150A.106.

120.14 (c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and  
120.15 drug counselor under chapter 148F.

120.16 (d) "Dental therapist" means an individual who is licensed as a dental therapist under  
120.17 section 150A.06.

120.18 (e) "Dentist" means an individual who is licensed to practice dentistry.

120.19 (f) "Designated rural area" means a statutory and home rule charter city or township that  
120.20 is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,  
120.21 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

120.22 (g) "Emergency circumstances" means those conditions that make it impossible for the  
120.23 participant to fulfill the service commitment, including death, total and permanent disability,  
120.24 or temporary disability lasting more than two years.

120.25 (h) "Hospital nurse" means an individual who is licensed as a registered nurse and who  
120.26 is providing direct patient care in a nonprofit hospital setting.

120.27 (i) "Mental health professional" means an individual providing clinical services in the  
120.28 treatment of mental illness who is qualified in at least one of the ways specified in section  
120.29 245.462, subdivision 18.

120.30 ~~(j)~~ (j) "Medical resident" means an individual participating in a medical residency in  
120.31 family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

121.1 ~~(j)~~ (k) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse  
121.2 anesthetist, advanced clinical nurse specialist, or physician assistant.

121.3 ~~(k)~~ (l) "Nurse" means an individual who has completed training and received all licensing  
121.4 or certification necessary to perform duties as a licensed practical nurse or registered nurse.

121.5 ~~(l)~~ (m) "Nurse-midwife" means a registered nurse who has graduated from a program  
121.6 of study designed to prepare registered nurses for advanced practice as nurse-midwives.

121.7 ~~(m)~~ (n) "Nurse practitioner" means a registered nurse who has graduated from a program  
121.8 of study designed to prepare registered nurses for advanced practice as nurse practitioners.

ARTICLE 3 PROVISIONS

142.3 Sec. 47. Minnesota Statutes 2022, section 144.1501, subdivision 1, is amended to read:

142.4 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
142.5 apply.

142.6 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist  
142.7 under section 150A.06, and who is certified as an advanced dental therapist under section  
142.8 150A.106.

142.9 (c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and  
142.10 drug counselor under chapter 148F.

142.11 (d) "Dental therapist" means an individual who is licensed as a dental therapist under  
142.12 section 150A.06.

142.13 (e) "Dentist" means an individual who is licensed to practice dentistry.

142.14 (f) "Designated rural area" means a statutory and home rule charter city or township that  
142.15 is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,  
142.16 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

142.17 (g) "Emergency circumstances" means those conditions that make it impossible for the  
142.18 participant to fulfill the service commitment, including death, total and permanent disability,  
142.19 or temporary disability lasting more than two years.

142.20 (h) "Hospital nurse" means an individual who is licensed as a registered nurse and who  
142.21 is providing direct patient care in a nonprofit hospital setting.

142.22 (i) "Mental health professional" means an individual providing clinical services in the  
142.23 treatment of mental illness who is qualified in at least one of the ways specified in section  
142.24 245.462, subdivision 18.

142.25 ~~(j)~~ (j) "Medical resident" means an individual participating in a medical residency in  
142.26 family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

142.27 ~~(j)~~ (k) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse  
142.28 anesthetist, advanced clinical nurse specialist, or physician assistant.

142.29 ~~(k)~~ (l) "Nurse" means an individual who has completed training and received all licensing  
142.30 or certification necessary to perform duties as a licensed practical nurse or registered nurse.

143.1 ~~(l)~~ (m) "Nurse-midwife" means a registered nurse who has graduated from a program  
143.2 of study designed to prepare registered nurses for advanced practice as nurse-midwives.

143.3 ~~(m)~~ (n) "Nurse practitioner" means a registered nurse who has graduated from a program  
143.4 of study designed to prepare registered nurses for advanced practice as nurse practitioners.

121.9       ~~(n)~~ (o) "Pharmacist" means an individual with a valid license issued under chapter 151.

121.10       ~~(n)~~ (p) "Physician" means an individual who is licensed to practice medicine in the areas

121.11 of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

121.12       ~~(p)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

121.13       (r) "PSLF program" means the federal Public Service Loan Forgiveness program

121.14 established under Code of Federal Regulations, title 34, section 685.219.

121.15       ~~(q)~~ (s) "Public health nurse" means a registered nurse licensed in Minnesota who has

121.16 obtained a registration certificate as a public health nurse from the Board of Nursing in

121.17 accordance with Minnesota Rules, chapter 6316.

121.18       ~~(t)~~ (t) "Qualified educational loan" means a government, commercial, or foundation loan

121.19 for actual costs paid for tuition, reasonable education expenses, and reasonable living

121.20 expenses related to the graduate or undergraduate education of a health care professional.

121.21       ~~(s)~~ (u) "Underserved urban community" means a Minnesota urban area or population

121.22 included in the list of designated primary medical care health professional shortage areas

121.23 (HPSAs), medically underserved areas (MUAs), or medically underserved populations

121.24 (MUPs) maintained and updated by the United States Department of Health and Human

121.25 Services.

121.26       Sec. 2. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

121.27       Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness

121.28 program account is established. The commissioner of health shall use money from the

121.29 account to establish a loan forgiveness program:

122.1       (1) for medical residents, mental health professionals, and alcohol and drug counselors

122.2 agreeing to practice in designated rural areas or underserved urban communities or

122.3 specializing in the area of pediatric psychiatry;

122.4       (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach

122.5 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program

122.6 at the undergraduate level or the equivalent at the graduate level;

122.7       (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care

122.8 facility for persons with developmental disability; a hospital if the hospital owns and operates

122.9 a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse

122.10 is in the nursing home; a housing with services establishment as defined in section 144D.01,

122.11 subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or

122.12 agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a

122.13 postsecondary program at the undergraduate level or the equivalent at the graduate level;

143.5       ~~(n)~~ (o) "Pharmacist" means an individual with a valid license issued under chapter 151.

143.6       ~~(n)~~ (p) "Physician" means an individual who is licensed to practice medicine in the areas

143.7 of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

143.8       ~~(p)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

143.9       (r) "PSLF program" means the federal Public Service Loan Forgiveness program

143.10 established under Code of Federal Regulations, title 34, section 685.219.

143.11       ~~(q)~~ (s) "Public health nurse" means a registered nurse licensed in Minnesota who has

143.12 obtained a registration certificate as a public health nurse from the Board of Nursing in

143.13 accordance with Minnesota Rules, chapter 6316.

143.14       ~~(t)~~ (t) "Qualified educational loan" means a government, commercial, or foundation loan

143.15 for actual costs paid for tuition, reasonable education expenses, and reasonable living

143.16 expenses related to the graduate or undergraduate education of a health care professional.

143.17       ~~(s)~~ (u) "Underserved urban community" means a Minnesota urban area or population

143.18 included in the list of designated primary medical care health professional shortage areas

143.19 (HPSAs), medically underserved areas (MUAs), or medically underserved populations

143.20 (MUPs) maintained and updated by the United States Department of Health and Human

143.21 Services.

143.22       Sec. 48. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

143.23       Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness

143.24 program account is established. The commissioner of health shall use money from the

143.25 account to establish a loan forgiveness program:

143.26       (1) for medical residents, mental health professionals, and alcohol and drug counselors

143.27 agreeing to practice in designated rural areas or underserved urban communities or

143.28 specializing in the area of pediatric psychiatry;

143.29       (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach

143.30 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program

143.31 at the undergraduate level or the equivalent at the graduate level;

144.1       (3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate

144.2 care facility for persons with developmental disability; in a hospital if the hospital owns

144.3 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked

144.4 by the nurse is in the nursing home; a housing with services establishment as defined in

144.5 section 144D.01, subdivision 4 in an assisted living facility as defined in section 144G.08,

144.6 subdivision 7; or for a home care provider as defined in section 144A.43, subdivision 4; or

144.7 agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a

144.8 postsecondary program at the undergraduate level or the equivalent at the graduate level;

122.14 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720  
122.15 hours per year in their designated field in a postsecondary program at the undergraduate  
122.16 level or the equivalent at the graduate level. The commissioner, in consultation with the  
122.17 Healthcare Education-Industry Partnership, shall determine the health care fields where the  
122.18 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory  
122.19 technology, radiologic technology, and surgical technology;

122.20 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses  
122.21 who agree to practice in designated rural areas; ~~and~~

122.22 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient  
122.23 encounters to state public program enrollees or patients receiving sliding fee schedule  
122.24 discounts through a formal sliding fee schedule meeting the standards established by the  
122.25 United States Department of Health and Human Services under Code of Federal Regulations,  
122.26 title 42, section 51, chapter 303; and

122.27 (7) for nurses who are enrolled in the PSLF program, employed as a hospital nurse by  
122.28 a nonprofit hospital that is an eligible employer under the PSLF program, and providing  
122.29 direct care to patients at the nonprofit hospital.

122.30 (b) Appropriations made to the account do not cancel and are available until expended,  
122.31 except that at the end of each biennium, any remaining balance in the account that is not  
122.32 committed by contract and not needed to fulfill existing commitments shall cancel to the  
122.33 fund.

123.1 Sec. 3. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

123.2 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an  
123.3 individual must:

123.4 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or  
123.5 education program to become a dentist, dental therapist, advanced dental therapist, mental  
123.6 health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel  
123.7 practitioner, registered nurse, or a licensed practical nurse. The commissioner may also  
123.8 consider applications submitted by graduates in eligible professions who are licensed and  
123.9 in practice; and

123.10 (2) submit an application to the commissioner of health. Nurses applying under  
123.11 subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is enrolled  
123.12 in the PSLF program and confirmation that the applicant is employed as a hospital nurse.

123.13 (b) An applicant selected to participate must sign a contract to agree to serve a minimum  
123.14 three-year full-time service obligation according to subdivision 2, which shall begin no later  
123.15 than March 31 following completion of required training, with the exception of:

144.9 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720  
144.10 hours per year in their designated field in a postsecondary program at the undergraduate  
144.11 level or the equivalent at the graduate level. The commissioner, in consultation with the  
144.12 Healthcare Education-Industry Partnership, shall determine the health care fields where the  
144.13 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory  
144.14 technology, radiologic technology, and surgical technology;

144.15 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses  
144.16 who agree to practice in designated rural areas; ~~and~~

144.17 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient  
144.18 encounters to state public program enrollees or patients receiving sliding fee schedule  
144.19 discounts through a formal sliding fee schedule meeting the standards established by the  
144.20 United States Department of Health and Human Services under Code of Federal Regulations,  
144.21 title 42, section 51, chapter 303; 51c.303; and

144.22 (7) for nurses who are enrolled in the PSLF program, employed as a hospital nurse by  
144.23 a nonprofit hospital that is an eligible employer under the PSLF program, and providing  
144.24 direct care to patients at the nonprofit hospital.

144.25 (b) Appropriations made to the account do not cancel and are available until expended,  
144.26 except that at the end of each biennium, any remaining balance in the account that is not  
144.27 committed by contract and not needed to fulfill existing commitments shall cancel to the  
144.28 fund.

144.29 Sec. 49. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

144.30 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an  
144.31 individual must:

144.32 (1) be a medical or dental resident; be a licensed pharmacist; or be enrolled in a training  
144.33 or education program or obtaining required supervision hours to become a dentist, dental  
145.1 therapist, advanced dental therapist, mental health professional, alcohol and drug counselor,  
145.2 pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical  
145.3 nurse. The commissioner may also consider applications submitted by graduates in eligible  
145.4 professions who are licensed and in practice; and

145.5 (2) submit an application to the commissioner of health. Nurses applying under  
145.6 subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is enrolled  
145.7 in the PSLF program and confirmation that the applicant is employed as a hospital nurse.

145.8 (b) An applicant selected to participate must sign a contract to agree to serve a minimum  
145.9 three-year full-time service obligation according to subdivision 2, which shall begin no later  
145.10 than March 31 following completion of required training, with the exception of:

123.16 (1) a nurse, who must agree to serve a minimum two-year full-time service obligation  
123.17 according to subdivision 2, which shall begin no later than March 31 following completion  
123.18 of required training;

123.19 (2) a nurse selected under subdivision 2, paragraph (a), clause (7), must agree to continue  
123.20 as a hospital nurse for the repayment period of the participant's eligible loan under the PSLF  
123.21 program; and

123.22 (3) a nurse who agrees to teach according to subdivision 2, paragraph (a), clause (3),  
123.23 must sign a contract to agree to teach for a minimum of two years.

123.24 Sec. 4. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

123.25 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each  
123.26 year for participation in the loan forgiveness program, within the limits of available funding.  
123.27 In considering applications, the commissioner shall give preference to applicants who  
123.28 document diverse cultural competencies. The commissioner shall distribute available funds  
123.29 for loan forgiveness proportionally among the eligible professions according to the vacancy  
123.30 rate for each profession in the required geographic area, facility type, teaching area, patient  
123.31 group, or specialty type specified in subdivision 2, except for hospital nurses. The  
123.32 commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the  
123.33 funds available are used for rural physician loan forgiveness and 25 percent of the funds  
124.1 available are used for underserved urban communities and pediatric psychiatry loan  
124.2 forgiveness. If the commissioner does not receive enough qualified applicants each year to  
124.3 use the entire allocation of funds for any eligible profession, the remaining funds may be  
124.4 allocated proportionally among the other eligible professions according to the vacancy rate  
124.5 for each profession in the required geographic area, patient group, or facility type specified  
124.6 in subdivision 2. Applicants are responsible for securing their own qualified educational  
124.7 loans. The commissioner shall select participants based on their suitability for practice  
124.8 serving the required geographic area or facility type specified in subdivision 2, as indicated  
124.9 by experience or training. The commissioner shall give preference to applicants closest to  
124.10 completing their training. Except as specified in paragraphs (b) and (c), for each year that  
124.11 a participant meets the service obligation required under subdivision 3, up to a maximum  
124.12 of four years, the commissioner shall make annual disbursements directly to the participant  
124.13 equivalent to 15 percent of the average educational debt for indebted graduates in their  
124.14 profession in the year closest to the applicant's selection for which information is available,  
124.15 not to exceed the balance of the participant's qualifying educational loans. Before receiving  
124.16 loan repayment disbursements and as requested, the participant must complete and return  
124.17 to the commissioner a confirmation of practice form provided by the commissioner verifying  
124.18 that the participant is practicing as required under subdivisions 2 and 3. The participant  
124.19 must provide the commissioner with verification that the full amount of loan repayment  
124.20 disbursement received by the participant has been applied toward the designated loans.  
124.21 After each disbursement, verification must be received by the commissioner and approved  
124.22 before the next loan repayment disbursement is made. Participants who move their practice

145.11 (1) a nurse, who must agree to serve a minimum two-year full-time service obligation  
145.12 according to subdivision 2, which shall begin no later than March 31 following completion  
145.13 of required training;

145.14 (2) a nurse selected under subdivision 2, paragraph (a), clause (7), who must agree to  
145.15 continue as a hospital nurse for the repayment period of the participant's eligible loan under  
145.16 the PSLF program; and

145.17 (3) a nurse who agrees to teach according to subdivision 2, paragraph (a), clause (3),  
145.18 who must sign a contract to agree to teach for a minimum of two years.

145.19 Sec. 50. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

145.20 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each  
145.21 year for participation in the loan forgiveness program, within the limits of available funding.  
145.22 In considering applications, the commissioner shall give preference to applicants who  
145.23 document diverse cultural competencies. The commissioner shall distribute available funds  
145.24 for loan forgiveness proportionally among the eligible professions according to the vacancy  
145.25 rate for each profession in the required geographic area, facility type, teaching area, patient  
145.26 group, or specialty type specified in subdivision 2, except for hospital nurses. The  
145.27 commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the  
145.28 funds available are used for rural physician loan forgiveness and 25 percent of the funds  
145.29 available are used for underserved urban communities and pediatric psychiatry loan  
145.30 forgiveness. If the commissioner does not receive enough qualified applicants each year to  
145.31 use the entire allocation of funds for any eligible profession, the remaining funds may be  
145.32 allocated proportionally among the other eligible professions according to the vacancy rate  
145.33 for each profession in the required geographic area, patient group, or facility type specified  
146.1 in subdivision 2. Applicants are responsible for securing their own qualified educational  
146.2 loans. The commissioner shall select participants based on their suitability for practice  
146.3 serving the required geographic area or facility type specified in subdivision 2, as indicated  
146.4 by experience or training. The commissioner shall give preference to applicants closest to  
146.5 completing their training. Except as specified in paragraphs (b) and (c), for each year that  
146.6 a participant meets the service obligation required under subdivision 3, up to a maximum  
146.7 of four years, the commissioner shall make annual disbursements directly to the participant  
146.8 equivalent to 15 percent of the average educational debt for indebted graduates in their  
146.9 profession in the year closest to the applicant's selection for which information is available,  
146.10 not to exceed the balance of the participant's qualifying educational loans. Before receiving  
146.11 loan repayment disbursements and as requested, the participant must complete and return  
146.12 to the commissioner a confirmation of practice form provided by the commissioner verifying  
146.13 that the participant is practicing as required under subdivisions 2 and 3. The participant  
146.14 must provide the commissioner with verification that the full amount of loan repayment  
146.15 disbursement received by the participant has been applied toward the designated loans.  
146.16 After each disbursement, verification must be received by the commissioner and approved  
146.17 before the next loan repayment disbursement is made. Participants who move their practice

124.23 remain eligible for loan repayment as long as they practice as required under subdivision  
124.24 2.

124.25 (b) For hospital nurses, the commissioner of health shall select applicants each year for  
124.26 participation in the hospital nursing education loan forgiveness program, within limits of  
124.27 available funding for hospital nurses. Applicants are responsible for applying for and  
124.28 maintaining eligibility for the PSLF program. For each year that a participant meets the  
124.29 eligibility requirements described in subdivision 3, the commissioner shall make an annual  
124.30 disbursement directly to the participant in an amount equal to the minimum loan payments  
124.31 required to be paid by the participant under the participant's repayment plan established for  
124.32 the participant under the PSLF program for the previous loan year. Before receiving the  
124.33 annual loan repayment disbursement, the participant must complete and return to the  
124.34 commissioner a confirmation of practice form provided by the commissioner, verifying that  
124.35 the participant continues to meet the eligibility requirements under subdivision 3. The  
124.36 participant must provide the commissioner with verification that the full amount of loan  
125.1 repayment disbursement received by the participant has been applied toward the loan for  
125.2 which forgiveness is sought under the PSLF program.

125.3 (c) For each year that a participant who is a nurse and who has agreed to teach according  
125.4 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner  
125.5 shall make annual disbursements directly to the participant equivalent to 15 percent of the  
125.6 average annual educational debt for indebted graduates in the nursing profession in the year  
125.7 closest to the participant's selection for which information is available, not to exceed the  
125.8 balance of the participant's qualifying educational loans.

125.9 Sec. 5. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

125.10 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required  
125.11 minimum commitment of service according to subdivision 3; or, for hospital nurses, the  
125.12 secretary of education determines that the participant does not meet eligibility requirements  
125.13 for the PSLF, the commissioner of health shall collect from the participant the total amount  
125.14 paid to the participant under the loan forgiveness program plus interest at a rate established  
125.15 according to section 270C.40. The commissioner shall deposit the money collected in the  
125.16 health care access fund to be credited to the health professional education loan forgiveness  
125.17 program account established in subdivision 2. The commissioner shall allow waivers of all  
125.18 or part of the money owed the commissioner as a result of a nonfulfillment penalty if  
125.19 emergency circumstances prevented fulfillment of the minimum service commitment or,  
125.20 for hospital nurses, if the PSLF program is discontinued before the participant's service  
125.21 commitment is fulfilled.

125.22 Sec. 6. Minnesota Statutes 2022, section 144.566, is amended to read:

125.23 **144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.**

125.24 Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have  
125.25 the meanings given.

146.18 remain eligible for loan repayment as long as they practice as required under subdivision  
146.19 2.

146.20 (b) For hospital nurses, the commissioner of health shall select applicants each year for  
146.21 participation in the hospital nursing education loan forgiveness program, within limits of  
146.22 available funding for hospital nurses. Applicants are responsible for applying for and  
146.23 maintaining eligibility for the PSLF program. For each year that a participant meets the  
146.24 eligibility requirements described in subdivision 3, the commissioner shall make an annual  
146.25 disbursement directly to the participant in an amount equal to the minimum loan payments  
146.26 required to be paid by the participant under the participant's repayment plan established for  
146.27 the participant under the PSLF program for the previous loan year. Before receiving the  
146.28 annual loan repayment disbursement, the participant must complete and return to the  
146.29 commissioner a confirmation of practice form provided by the commissioner, verifying that  
146.30 the participant continues to meet the eligibility requirements under subdivision 3. The  
146.31 participant must provide the commissioner with verification that the full amount of loan  
146.32 repayment disbursement received by the participant has been applied toward the loan for  
146.33 which forgiveness is sought under the PSLF program.

146.34 (c) For each year that a participant who is a nurse and who has agreed to teach according  
146.35 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner  
147.1 shall make annual disbursements directly to the participant equivalent to 15 percent of the  
147.2 average annual educational debt for indebted graduates in the nursing profession in the year  
147.3 closest to the participant's selection for which information is available, not to exceed the  
147.4 balance of the participant's qualifying educational loans.

147.5 Sec. 51. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

147.6 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required  
147.7 minimum commitment of service according to subdivision 3; or for hospital nurses, if the  
147.8 secretary of education determines that the participant does not meet eligibility requirements  
147.9 for the PSLF, the commissioner of health shall collect from the participant the total amount  
147.10 paid to the participant under the loan forgiveness program plus interest at a rate established  
147.11 according to section 270C.40. The commissioner shall deposit the money collected in the  
147.12 health care access fund to be credited to the health professional education loan forgiveness  
147.13 program account established in subdivision 2. The commissioner shall allow waivers of all  
147.14 or part of the money owed the commissioner as a result of a nonfulfillment penalty if  
147.15 emergency circumstances prevented fulfillment of the minimum service commitment or  
147.16 for hospital nurses, if the PSLF program is discontinued before the participant's service  
147.17 commitment is fulfilled.

164.1 Sec. 72. Minnesota Statutes 2022, section 144.566, is amended to read:

164.2 **144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.**

164.3 Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have  
164.4 the meanings given.

125.26 (b) "Act of violence" means an act by a patient or visitor against a health care worker  
 125.27 that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections  
 125.28 609.221 to 609.2241.

125.29 (c) "Commissioner" means the commissioner of health.

125.30 (d) "Health care worker" means any person, whether licensed or unlicensed, employed  
 125.31 by, volunteering in, or under contract with a hospital, who has direct contact with a patient  
 126.1 of the hospital for purposes of either medical care or emergency response to situations  
 126.2 potentially involving violence.

126.3 (e) "Hospital" means any facility licensed as a hospital under section 144.55.

126.4 (f) "Incident response" means the actions taken by hospital administration and health  
 126.5 care workers during and following an act of violence.

126.6 (g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's  
 126.7 ability to report acts of violence, including by retaliating or threatening to retaliate against  
 126.8 a health care worker.

126.9 (h) "Preparedness" means the actions taken by hospital administration and health care  
 126.10 workers to prevent a single act of violence or acts of violence generally.

126.11 (i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against,  
 126.12 or penalize a health care worker regarding the health care worker's compensation, terms,  
 126.13 conditions, location, or privileges of employment.

126.14 (j) "Workplace violence hazards" means locations and situations where violent incidents  
 126.15 are more likely to occur, including, as applicable, but not limited to locations isolated from  
 126.16 other health care workers; health care workers working alone; health care workers working  
 126.17 in remote locations; health care workers working late night or early morning hours; locations  
 126.18 where an assailant could prevent entry of responders or other health care workers into a  
 126.19 work area; locations with poor illumination; locations with poor visibility; lack of effective  
 126.20 escape routes; obstacles and impediments to accessing alarm systems; locations within the  
 126.21 facility where alarm systems are not operational; entryways where unauthorized entrance  
 126.22 may occur, such as doors designated for staff entrance or emergency exits; presence, in the  
 126.23 areas where patient contact activities are performed, of furnishings or objects that could be  
 126.24 used as weapons; and locations where high-value items, currency, or pharmaceuticals are  
 126.25 stored.

126.26 Subd. 2. ~~**Hospital duties**~~ **Action plans and action plan reviews required.** (a) All  
 126.27 hospitals must design and implement preparedness and incident response action plans to  
 126.28 acts of violence by January 15, 2016, and review and update the plan at least annually  
 126.29 thereafter. The plan must be in writing; specific to the workplace violence hazards and

164.5 (b) "Act of violence" means an act by a patient or visitor against a health care worker  
 164.6 that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections  
 164.7 609.221 to 609.2241.

164.8 (c) "Commissioner" means the commissioner of health.

164.9 (d) "Health care worker" means any person, whether licensed or unlicensed, employed  
 164.10 by, volunteering in, or under contract with a hospital, who has direct contact with a patient  
 164.11 of the hospital for purposes of either medical care or emergency response to situations  
 164.12 potentially involving violence.

164.13 (e) "Hospital" means any facility licensed as a hospital under section 144.55.

164.14 (f) "Incident response" means the actions taken by hospital administration and health  
 164.15 care workers during and following an act of violence.

164.16 (g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's  
 164.17 ability to report acts of violence, including by retaliating or threatening to retaliate against  
 164.18 a health care worker.

164.19 (h) "Preparedness" means the actions taken by hospital administration and health care  
 164.20 workers to prevent a single act of violence or acts of violence generally.

164.21 (i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against,  
 164.22 or penalize a health care worker regarding the health care worker's compensation, terms,  
 164.23 conditions, location, or privileges of employment.

164.24 (j) "Workplace violence hazards" means locations and situations where violent incidents  
 164.25 are more likely to occur, including, as applicable, but not limited to locations isolated from  
 164.26 other health care workers; health care workers working alone; health care workers working  
 164.27 in remote locations; health care workers working late night or early morning hours; locations  
 164.28 where an assailant could prevent entry of responders or other health care workers into a  
 164.29 work area; locations with poor illumination; locations with poor visibility; lack of **physical**  
 164.30 barriers between health care workers and persons at risk of committing workplace violence;  
 164.31 lack of effective escape routes; obstacles and impediments to accessing alarm systems;  
 164.32 locations within the facility where alarm systems are not operational; entryways where  
 165.1 unauthorized entrance may occur, such as doors designated for staff entrance or emergency  
 165.2 exits; presence, in the areas where patient contact activities are performed, of furnishings  
 165.3 or objects that could be used as weapons; and locations where high-value items, currency,  
 165.4 or pharmaceuticals are stored.

165.5 Subd. 2. ~~**Hospital duties**~~ **Action plans and action plan reviews required.** (a) All  
 165.6 hospitals must design and implement preparedness and incident response action plans to  
 165.7 acts of violence by January 15, 2016, and review and update the plan at least annually  
 165.8 thereafter. The plan must be in writing; specific to the workplace violence hazards and

126.30 corrective measures for the units, services, or operations of the hospital; and available to  
 126.31 health care workers at all times.

126.32 Subd. 3. **Action plan committees.** ~~(b)~~ A hospital shall designate a committee of  
 126.33 representatives of health care workers employed by the hospital, including nonmanagerial  
 127.1 health care workers, nonclinical staff, administrators, patient safety experts, and other  
 127.2 appropriate personnel to develop preparedness and incident response action plans to acts  
 127.3 of violence. The hospital shall, in consultation with the designated committee, implement  
 127.4 the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall  
 127.5 require the establishment of a separate committee solely for the purpose required by this  
 127.6 subdivision.

127.7 Subd. 4. **Required elements of action plans; generally.** The preparedness and incident  
 127.8 response action plans to acts of violence must include:

127.9 (1) effective procedures to obtain the active involvement of health care workers and  
 127.10 their representatives in developing, implementing, and reviewing the plan, including their  
 127.11 participation in identifying, evaluating, and correcting workplace violence hazards, designing  
 127.12 and implementing training, and reporting and investigating incidents of workplace violence;

127.13 (2) names or job titles of the persons responsible for implementing the plan; and

127.14 (3) effective procedures to ensure that supervisory and nonsupervisory health care  
 127.15 workers comply with the plan.

127.16 Subd. 5. **Required elements of action plans; evaluation of risk factors.** (a) The  
 127.17 preparedness and incident response action plans to acts of violence must include assessment  
 127.18 procedures to identify and evaluate workplace violence hazards for each facility, unit,  
 127.19 service, or operation, including community-based risk factors and areas surrounding the  
 127.20 facility, such as employee parking areas and other outdoor areas. Procedures shall specify  
 127.21 the frequency ~~that~~ environmental assessments take place.

127.22 (b) The preparedness and incident response action plans to acts of violence must include  
 127.23 assessment tools, environmental checklists, or other effective means to identify workplace  
 127.24 violence hazards.

127.25 Subd. 6. **Required elements of action plans; review of workplace violence**  
 127.26 **incidents.** The preparedness and incident response action plans to acts of violence must  
 127.27 include procedures for reviewing all workplace violence incidents that occurred in the  
 127.28 facility, unit, service, or operation within the previous year, whether or not an injury occurred.

127.29 Subd. 7. **Required elements of action plans; reporting workplace violence.** The  
 127.30 preparedness and incident response action plans to acts of violence must include:

127.31 (1) effective procedures for health care workers to document information regarding  
 127.32 conditions that may increase the potential for workplace violence incidents and communicate  
 127.33 that information without fear of reprisal to other health care workers, shifts, or units;

165.9 corrective measures for the units, services, or operations of the hospital; and available to  
 165.10 health care workers at all times.

165.11 Subd. 3. **Action plan committees.** ~~(b)~~ A hospital shall designate a committee of  
 165.12 representatives of health care workers employed by the hospital, including nonmanagerial  
 165.13 health care workers, nonclinical staff, administrators, patient safety experts, and other  
 165.14 appropriate personnel to develop preparedness and incident response action plans to acts  
 165.15 of violence. The hospital shall, in consultation with the designated committee, implement  
 165.16 the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall  
 165.17 require the establishment of a separate committee solely for the purpose required by this  
 165.18 subdivision.

165.19 Subd. 4. **Required elements of action plans; generally.** The preparedness and incident  
 165.20 response action plans to acts of violence must include:

165.21 (1) effective procedures to obtain the active involvement of health care workers and  
 165.22 their representatives in developing, implementing, and reviewing the plan, including their  
 165.23 participation in identifying, evaluating, and correcting workplace violence hazards, designing  
 165.24 and implementing training, and reporting and investigating incidents of workplace violence;

165.25 (2) names or job titles of the persons responsible for implementing the plan; and

165.26 (3) effective procedures to ensure that supervisory and nonsupervisory health care  
 165.27 workers comply with the plan.

165.28 Subd. 5. **Required elements of action plans; evaluation of risk factors.** (a) The  
 165.29 preparedness and incident response action plans to acts of violence must include assessment  
 165.30 procedures to identify and evaluate workplace violence hazards for each facility, unit,  
 165.31 service, or operation, including community-based risk factors and areas surrounding the  
 165.32 facility, such as employee parking areas and other outdoor areas. Procedures shall specify  
 165.33 the frequency ~~with which such~~ environmental assessments ~~will~~ take place.

166.1 (b) The preparedness and incident response action plans to acts of violence must include  
 166.2 assessment tools, environmental checklists, or other effective means to identify workplace  
 166.3 violence hazards.

166.4 Subd. 6. **Required elements of action plans; review of workplace violence**  
 166.5 **incidents.** The preparedness and incident response action plans to acts of violence must  
 166.6 include procedures for reviewing all workplace violence incidents that occurred in the  
 166.7 facility, unit, service, or operation within the previous year, whether or not an injury occurred.

166.8 Subd. 7. **Required elements of action plans; reporting workplace violence.** The  
 166.9 preparedness and incident response action plans to acts of violence must include:

166.10 (1) effective procedures for health care workers to document information regarding  
 166.11 conditions that may increase the potential for workplace violence incidents and communicate  
 166.12 that information without fear of reprisal to other health care workers, shifts, or units;



128.1 (2) effective procedures for health care workers to report a violent incident, threat, or  
128.2 other workplace violence concern without fear of reprisal;

128.3 (3) effective procedures for the hospital to accept and respond to reports of workplace  
128.4 violence and to prohibit retaliation against a health care worker who makes such a report;

128.5 (4) a policy statement stating the hospital will not prevent a health care worker from  
128.6 reporting workplace violence or take punitive or retaliatory action against a health care  
128.7 worker for doing so;

128.8 (5) effective procedures for investigating health care worker concerns regarding workplace  
128.9 violence or workplace violence hazards;

128.10 (6) procedures for informing health care workers of the results of the investigation arising  
128.11 from a report of workplace violence or from a concern about a workplace violence hazard  
128.12 and of any corrective actions taken;

128.13 (7) effective procedures for obtaining assistance from the appropriate law enforcement  
128.14 agency or social service agency during all work shifts. The procedure may establish a central  
128.15 coordination procedure; and

128.16 (8) a policy statement stating the hospital will not prevent a health care worker from  
128.17 seeking assistance and intervention from local emergency services or law enforcement when  
128.18 a violent incident occurs or take punitive or retaliatory action against a health care worker  
128.19 for doing so.

128.20 Subd. 8. **Required elements of action plans; coordination with other employers.** The  
128.21 preparedness and incident response action plans to acts of violence must include methods  
128.22 the hospital will use to coordinate implementation of the plan with other employers whose  
128.23 employees work in the same health care facility, unit, service, or operation and to ensure  
128.24 that those employers and their employees understand their respective roles as provided in  
128.25 the plan. These methods must ensure that all employees working in the facility, unit, service,  
128.26 or operation are provided the training required by subdivision 11 and that workplace violence  
128.27 incidents involving any employee are reported, investigated, and recorded.

128.28 Subd. 9. **Required elements of action plans; white supremacist affiliation and support**  
128.29 **prohibited.** (a) The preparedness and incident response action plans to acts of violence  
128.30 must include a policy statement stating that security personnel employed by the hospital or  
128.31 assigned to the hospital by a contractor are prohibited from affiliating with, supporting, or  
128.32 advocating for white supremacist groups, causes, or ideologies or participating in, or actively  
129.1 promoting, an international or domestic extremist group that the Federal Bureau of  
129.2 Investigation has determined supports or encourages illegal, violent conduct.

129.3 (b) For purposes of this subdivision, white supremacist groups, causes, or ideologies  
129.4 include organizations and associations and ideologies that promote white supremacy and  
129.5 the idea that white people are superior to Black, Indigenous, and people of color (BIPOC);  
129.6 promote religious and racial bigotry; seek to exacerbate racial and ethnic tensions between

166.13 (2) effective procedures for health care workers to report a violent incident, threat, or  
166.14 other workplace violence concern without fear of reprisal;

166.15 (3) effective procedures for the hospital to accept and respond to reports of workplace  
166.16 violence and to prohibit retaliation against a health care worker who makes such a report;

166.17 (4) a policy statement stating the hospital will not prevent a health care worker from  
166.18 reporting workplace violence or take punitive or retaliatory action against a health care  
166.19 worker for doing so;

166.20 (5) effective procedures for investigating health care worker concerns regarding workplace  
166.21 violence or workplace violence hazards;

166.22 (6) procedures for informing health care workers of the results of the investigation arising  
166.23 from a report of workplace violence or from a concern about a workplace violence hazard  
166.24 and of any corrective actions taken;

166.25 (7) effective procedures for obtaining assistance from the appropriate law enforcement  
166.26 agency or social service agency during all work shifts. The procedure may establish a central  
166.27 coordination procedure; and

166.28 (8) a policy statement stating the hospital will not prevent a health care worker from  
166.29 seeking assistance and intervention from local emergency services or law enforcement when  
166.30 a violent incident occurs or take punitive or retaliatory action against a health care worker  
166.31 for doing so.

167.1 Subd. 8. **Required elements of action plans; coordination with other employers.** The  
167.2 preparedness and incident response action plans to acts of violence must include methods  
167.3 the hospital will use to coordinate implementation of the plan with other employers whose  
167.4 employees work in the same health care facility, unit, service, or operation and to ensure  
167.5 that those employers and their employees understand their respective roles as provided in  
167.6 the plan. These methods must ensure that all employees working in the facility, unit, service,  
167.7 or operation are provided the training required by subdivision 11 and that workplace violence  
167.8 incidents involving any employee are reported, investigated, and recorded.

167.9 Subd. 9. **Required elements of action plans; white supremacist affiliation and support**  
167.10 **prohibited.** (a) The preparedness and incident response action plans to acts of violence  
167.11 must include a policy statement stating that security personnel employed by the hospital or  
167.12 assigned to the hospital by a contractor are prohibited from affiliating with, supporting, or  
167.13 advocating for white supremacist groups, causes, or ideologies or participating in, or actively  
167.14 promoting, an international or domestic extremist group that the Federal Bureau of  
167.15 Investigation has determined supports or encourages illegal, violent conduct.

167.16 (b) For purposes of this subdivision, white supremacist groups, causes, or ideologies  
167.17 include organizations and associations and ideologies that promote white supremacy and  
167.18 the idea that white people are superior to Black, Indigenous, and people of color (BIPOC);  
167.19 promote religious and racial bigotry; seek to exacerbate racial and ethnic tensions between



129.7 BIPOC and non-BIPOC; or engage in patently hateful and inflammatory speech, intimidation,  
129.8 and violence against BIPOC as means of promoting white supremacy.

129.9 Subd. 10. **Required elements of action plans; training.** (a) The preparedness and  
129.10 incident response action plans to acts of violence must include:

129.11 (1) procedures for developing and providing the training required in subdivision 11 that  
129.12 permits health care workers and their representatives to participate in developing the training;  
129.13 and

129.14 (2) a requirement for cultural competency training and equity, diversity, and inclusion  
129.15 training.

129.16 (b) The preparedness and incident response action plans to acts of violence must include  
129.17 procedures to communicate with health care workers regarding workplace violence matters,  
129.18 including:

129.19 (1) how health care workers will document and communicate to other health care workers  
129.20 and between shifts and units information regarding conditions that may increase the potential  
129.21 for workplace violence incidents;

129.22 (2) how health care workers can report a violent incident, threat, or other workplace  
129.23 violence concern;

129.24 (3) how health care workers can communicate workplace violence concerns without  
129.25 fear of reprisal; and

129.26 (4) how health care worker concerns will be investigated, and how health care workers  
129.27 will be informed of the results of the investigation and any corrective actions to be taken.

129.28 Subd. 11. **Training required.** ~~(e)~~ A hospital ~~shall~~ **must** provide training to all health  
129.29 care workers employed or contracted with the hospital on safety during acts of violence.  
129.30 Each health care worker must receive safety training ~~annually and upon hire~~ during the  
129.31 health care worker's orientation and before the health care worker completes a shift  
129.32 independently, and annually thereafter. Training must, at a minimum, include:

130.1 (1) safety guidelines for response to and de-escalation of an act of violence;

130.2 (2) ways to identify potentially violent or abusive situations, including aggression and  
130.3 violence predicting factors; ~~and~~

130.4 (3) the hospital's ~~incident response reaction plan and violence prevention plan~~  
130.5 preparedness and incident response action plans for acts of violence, including how the  
130.6 health care worker may report concerns about workplace violence within each hospital's  
130.7 reporting structure without fear of reprisal, how the hospital will address workplace violence  
130.8 incidents, and how the health care worker can participate in reviewing and revising the plan;  
130.9 and

167.20 BIPOC and non-BIPOC; or engage in patently hateful and inflammatory speech, intimidation,  
167.21 and violence against BIPOC as means of promoting white supremacy.

167.22 Subd. 10. **Required elements of action plans; training.** (a) The preparedness and  
167.23 incident response action plans to acts of violence must include:

167.24 (1) procedures for developing and providing the training required in subdivision 11 that  
167.25 permits health care workers and their representatives to participate in developing the training;  
167.26 and

167.27 (2) a requirement for cultural competency training and equity, diversity, and inclusion  
167.28 training.

167.29 (b) The preparedness and incident response action plans to acts of violence must include  
167.30 procedures to communicate with health care workers regarding workplace violence matters,  
167.31 including:

167.32 (1) how health care workers will document and communicate to other health care workers  
167.33 and between shifts and units information regarding conditions that may increase the potential  
167.34 for workplace violence incidents;

168.1 (2) how health care workers can report a violent incident, threat, or other workplace  
168.2 violence concern;

168.3 (3) how health care workers can communicate workplace violence concerns without  
168.4 fear of reprisal; and

168.5 (4) how health care worker concerns will be investigated, and how health care workers  
168.6 will be informed of the results of the investigation and any corrective actions to be taken.

168.7 Subd. 11. **Training required.** ~~(e)~~ A hospital ~~shall~~ **must** provide training to all health  
168.8 care workers employed or contracted with the hospital on safety during acts of violence.  
168.9 Each health care worker must receive safety training ~~annually and upon hire~~ during the  
168.10 health care worker's orientation and before the health care worker completes a shift  
168.11 independently, and annually thereafter. Training must, at a minimum, include:

168.12 (1) safety guidelines for response to and de-escalation of an act of violence;

168.13 (2) ways to identify potentially violent or abusive situations, including aggression and  
168.14 violence predicting factors; ~~and~~

168.15 (3) the hospital's ~~incident response reaction plan and violence prevention plan~~  
168.16 preparedness and incident response action plans for acts of violence, including how the  
168.17 health care worker may report concerns about workplace violence within each hospital's  
168.18 reporting structure without fear of reprisal, how the hospital will address workplace violence  
168.19 incidents, and how the health care worker can participate in reviewing and revising the plan;  
168.20 and

130.10 (4) any resources available to health care workers for coping with incidents of violence,  
130.11 including but not limited to critical incident stress debriefing or employee assistance  
130.12 programs.

130.13 Subd. 12. **Annual review and update of action plans.** ~~(d)~~ (a) As part of its annual  
130.14 review of preparedness and incident response action plans required under ~~paragraph (a)~~  
130.15 subdivision 2, the hospital must review with the designated committee:

130.16 (1) the effectiveness of its preparedness and incident response action plans, including  
130.17 the sufficiency of security systems, alarms, emergency responses, and security personnel  
130.18 availability;

130.19 (2) security risks associated with specific units, areas of the facility with uncontrolled  
130.20 access, late night shifts, early morning shifts, and areas surrounding the facility such as  
130.21 employee parking areas and other outdoor areas;

130.22 (3) the most recent gap analysis as provided by the commissioner; ~~and~~

130.23 ~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous  
130.24 year, including injuries sustained, if any, and the unit in which the incident occurred;

130.25 (5) evaluations of staffing, including staffing patterns and patient classification systems  
130.26 that contribute to, or are insufficient to address, the risk of violence; and

130.27 (6) any reports of discrimination or abuse that arise from security resources, including  
130.28 from the behavior of security personnel.

130.29 (b) As part of the annual update of preparedness and incident response action plans  
130.30 required under subdivision 2, the hospital must incorporate corrective actions into the action  
130.31 plan to address workplace violence hazards identified during the annual action plan review,  
131.1 reports of workplace violence, reports of workplace violence hazards, and reports of  
131.2 discrimination or abuse that arise from the security resources.

131.3 Subd. 13. **Action plan updates.** Following the annual review of the action plan, a hospital  
131.4 must update the action plans to reflect the corrective actions the hospital will implement to  
131.5 mitigate the hazards and vulnerabilities identified during the annual review.

131.6 Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a  
131.7 procedure for a health care worker to officially request of hospital supervisors or  
131.8 administration that additional staffing be provided. The hospital must document all requests  
131.9 for additional staffing made because of a health care worker's concern over a risk of an act  
131.10 of violence. If the request for additional staffing to reduce the risk of violence is denied,  
131.11 the hospital must provide the health care worker who made the request a written reason for  
131.12 the denial and must maintain documentation of that communication with the documentation  
131.13 of requests for additional staffing. A hospital must make documentation regarding staffing  
131.14 requests available to the commissioner for inspection at the commissioner's request. The  
131.15 commissioner may use documentation regarding staffing requests to inform the  
131.16 commissioner's determination on whether the hospital is providing adequate staffing and

168.21 (4) any resources available to health care workers for coping with incidents of violence,  
168.22 including but not limited to critical incident stress debriefing or employee assistance  
168.23 programs.

168.24 Subd. 12. **Annual review and update of action plans.** ~~(d)~~ (a) As part of its annual  
168.25 review of preparedness and incident response action plans required under ~~paragraph (a)~~  
168.26 subdivision 2, the hospital must review with the designated committee:

168.27 (1) the effectiveness of its preparedness and incident response action plans, including  
168.28 the sufficiency of security systems, alarms, emergency responses, and security personnel  
168.29 availability;

168.30 (2) security risks associated with specific units, areas of the facility with uncontrolled  
168.31 access, late night shifts, early morning shifts, and areas surrounding the facility such as  
168.32 employee parking areas and other outdoor areas;

169.1 (3) the most recent gap analysis as provided by the commissioner; ~~and~~

169.2 ~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous  
169.3 year, including injuries sustained, if any, and the unit in which the incident occurred;

169.4 (5) evaluations of staffing, including staffing patterns and patient classification systems  
169.5 that contribute to, or are insufficient to address, the risk of violence; and

169.6 (6) any reports of discrimination or abuse that arise from security resources, including  
169.7 from the behavior of security personnel.

169.8 (b) As part of the annual update of preparedness and incident response action plans  
169.9 required under subdivision 2, the hospital must incorporate corrective actions into the action  
169.10 plan to address workplace violence hazards identified during the annual action plan review,  
169.11 reports of workplace violence, reports of workplace violence hazards, and reports of  
169.12 discrimination or abuse that arise from the security resources.

169.13 Subd. 13. **Action plan updates.** Following the annual review of the action plan, a hospital  
169.14 must update the action plans to reflect the corrective actions the hospital will implement to  
169.15 mitigate the hazards and vulnerabilities identified during the annual review.

169.16 Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a  
169.17 procedure for a health care worker to officially request of hospital supervisors or  
169.18 administration that additional staffing be provided. The hospital must document all requests  
169.19 for additional staffing made because of a health care worker's concern over a risk of an act  
169.20 of violence. If the request for additional staffing to reduce the risk of violence is denied,  
169.21 the hospital must provide the health care worker who made the request a written reason for  
169.22 the denial and must maintain documentation of that communication with the documentation  
169.23 of requests for additional staffing. A hospital must make documentation regarding staffing  
169.24 requests available to the commissioner for inspection at the commissioner's request. The  
169.25 commissioner may use documentation regarding staffing requests to inform the  
169.26 commissioner's determination on whether the hospital is providing adequate staffing and

131.17 security to address acts of violence, and may use documentation regarding staffing requests  
 131.18 if the commissioner imposes a penalty under subdivision 18.

131.19 Subd. 15. **Disclosure of action plans.** ~~(e)~~ (a) A hospital ~~shall~~ must make its most recent  
 131.20 action plans and ~~the information listed in paragraph (d)~~ most recent action plan reviews  
 131.21 available to local law enforcement, all direct care staff and, if any of its workers are  
 131.22 represented by a collective bargaining unit, to the exclusive bargaining representatives of  
 131.23 those collective bargaining units.

131.24 (b) Beginning January 1, 2025, a hospital must annually submit to the commissioner its  
 131.25 most recent action plan and the results of the most recent annual review conducted under  
 131.26 subdivision 12.

131.27 Subd. 16. **Legislative report required.** (a) Beginning January 15, 2026, the commissioner  
 131.28 must compile the information into a single annual report and submit the report to the chairs  
 131.29 and ranking minority members of the legislative committees with jurisdiction over health  
 131.30 care by January 15 of each year.

131.31 (b) This subdivision does not expire.

131.32 Subd. 17. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner,  
 131.33 association, or any person or group of persons acting directly or indirectly in the interest of  
 131.34 the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health  
 132.1 care worker wishes to contact law enforcement or the commissioner regarding an act of  
 132.2 violence.

132.3 Subd. 18. **Penalties.** ~~(g)~~ Notwithstanding section 144.653, subdivision 6, the  
 132.4 commissioner may impose ~~an administrative~~ a fine of up to ~~\$250~~ \$10,000 for failure to  
 132.5 comply with the requirements of this ~~subdivision~~ section. The commissioner must allow  
 132.6 the hospital at least 30 calendar days to correct a violation of this section before assessing  
 132.7 a fine.

132.8 Sec. 7. Minnesota Statutes 2022, section 144.608, subdivision 1, is amended to read:

132.9 Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council  
 132.10 is established to advise, consult with, and make recommendations to the commissioner on  
 132.11 the development, maintenance, and improvement of a statewide trauma system.

132.12 (b) The council shall consist of the following members:

132.13 (1) a trauma surgeon certified by the American Board of Surgery or the American  
 132.14 Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

132.15 (2) a general surgeon certified by the American Board of Surgery or the American  
 132.16 Osteopathic Board of Surgery whose practice includes trauma and who practices in a  
 132.17 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

169.27 security to address acts of violence, and may use documentation regarding staffing requests  
 169.28 if the commissioner imposes a penalty under subdivision 18.

169.29 Subd. 15. **Disclosure of action plans.** ~~(e)~~ (a) A hospital ~~shall~~ must make its most recent  
 169.30 action plans and ~~the information listed in paragraph (d)~~ most recent action plan reviews  
 169.31 available to local law enforcement all direct care staff and, if any of its workers are  
 169.32 represented by a collective bargaining unit, to the exclusive bargaining representatives of  
 169.33 those collective bargaining units.

170.1 (b) A hospital must also annually submit to the commissioner its most recent action plan  
 170.2 and the results of the most recent annual review conducted under subdivision 12.

170.3 Subd. 16. **Legislative report required.** (a) The commissioner must compile the  
 170.4 information into a single annual report and submit the report to the chairs and ranking  
 170.5 minority members of the legislative committees with jurisdiction over health care by January  
 170.6 15 of each year.

170.7 (b) This subdivision does not expire.

170.8 Subd. 17. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner,  
 170.9 association, or any person or group of persons acting directly or indirectly in the interest of  
 170.10 the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health  
 170.11 care worker wishes to contact law enforcement or the commissioner regarding an act of  
 170.12 violence.

170.13 Subd. 18. **Penalties.** ~~(g)~~ Notwithstanding section 144.653, subdivision 6, the  
 170.14 commissioner may impose ~~an administrative~~ a fine of up to ~~\$250~~ \$10,000 for failure to  
 170.15 comply with the requirements of this ~~subdivision~~ section. The commissioner must allow  
 170.16 the hospital at least 30 calendar days to correct a violation of this section before assessing  
 170.17 a fine.

181.1 Sec. 77. Minnesota Statutes 2022, section 144.608, subdivision 1, is amended to read:

181.2 Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council  
 181.3 is established to advise, consult with, and make recommendations to the commissioner on  
 181.4 the development, maintenance, and improvement of a statewide trauma system.

181.5 (b) The council shall consist of the following members:

181.6 (1) a trauma surgeon certified by the American Board of Surgery or the American  
 181.7 Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

181.8 (2) a general surgeon certified by the American Board of Surgery or the American  
 181.9 Osteopathic Board of Surgery whose practice includes trauma and who practices in a  
 181.10 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

132.18 (3) a neurosurgeon certified by the American Board of Neurological Surgery who  
132.19 practices in a level I or II trauma hospital;

132.20 (4) a trauma program nurse manager or coordinator practicing in a level I or II trauma  
132.21 hospital;

132.22 (5) an emergency physician certified by the American Board of Emergency Medicine  
132.23 or the American Osteopathic Board of Emergency Medicine whose practice includes  
132.24 emergency room care in a level I, II, III, or IV trauma hospital;

132.25 (6) a trauma program manager or coordinator who practices in a level III or IV trauma  
132.26 hospital;

132.27 (7) a physician certified by the American Board of Family Medicine or the American  
132.28 Osteopathic Board of Family Practice whose practice includes emergency department care  
132.29 in a level III or IV trauma hospital located in a designated rural area as defined under section  
132.30 144.1501, subdivision 1, ~~paragraph (e)~~;

132.31 (8) a nurse practitioner, as defined under section 144.1501, subdivision 1, ~~paragraph (l)~~,  
132.32 or a physician assistant, as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;  
133.1 whose practice includes emergency room care in a level IV trauma hospital located in a  
133.2 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

133.3 (9) a physician certified in pediatric emergency medicine by the American Board of  
133.4 Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency  
133.5 Medicine or certified by the American Osteopathic Board of Pediatrics whose practice  
133.6 primarily includes emergency department medical care in a level I, II, III, or IV trauma  
133.7 hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose  
133.8 practice involves the care of pediatric trauma patients in a trauma hospital;

133.9 (10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or  
133.10 the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma  
133.11 and who practices in a level I, II, or III trauma hospital;

133.12 (11) the state emergency medical services medical director appointed by the Emergency  
133.13 Medical Services Regulatory Board;

133.14 (12) a hospital administrator of a level III or IV trauma hospital located in a designated  
133.15 rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

133.16 (13) a rehabilitation specialist whose practice includes rehabilitation of patients with  
133.17 major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under  
133.18 section 144.661;

133.19 (14) an attendant or ambulance director who is an EMT, ~~EMT-I~~, or ~~EMT-P~~ within the  
133.20 meaning of section 144E.001 and who actively practices with a licensed ambulance service  
133.21 in a primary service area located in a designated rural area as defined under section 144.1501,  
133.22 subdivision 1, ~~paragraph (e)~~; and

181.11 (3) a neurosurgeon certified by the American Board of Neurological Surgery who  
181.12 practices in a level I or II trauma hospital;

181.13 (4) a trauma program nurse manager or coordinator practicing in a level I or II trauma  
181.14 hospital;

181.15 (5) an emergency physician certified by the American Board of Emergency Medicine  
181.16 or the American Osteopathic Board of Emergency Medicine whose practice includes  
181.17 emergency room care in a level I, II, III, or IV trauma hospital;

181.18 (6) a trauma program manager or coordinator who practices in a level III or IV trauma  
181.19 hospital;

181.20 (7) a physician certified by the American Board of Family Medicine or the American  
181.21 Osteopathic Board of Family Practice whose practice includes emergency department care  
181.22 in a level III or IV trauma hospital located in a designated rural area as defined under section  
181.23 144.1501, subdivision 1, ~~paragraph (e)~~;

181.24 (8) a nurse practitioner, as defined under section 144.1501, subdivision 1, ~~paragraph (l)~~,  
181.25 or a physician assistant, as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;  
181.26 whose practice includes emergency room care in a level IV trauma hospital located in a  
181.27 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

181.28 (9) a physician certified in pediatric emergency medicine by the American Board of  
181.29 Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency  
181.30 Medicine or certified by the American Osteopathic Board of Pediatrics whose practice  
181.31 primarily includes emergency department medical care in a level I, II, III, or IV trauma  
182.1 hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose  
182.2 practice involves the care of pediatric trauma patients in a trauma hospital;

182.3 (10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or  
182.4 the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma  
182.5 and who practices in a level I, II, or III trauma hospital;

182.6 (11) the state emergency medical services medical director appointed by the Emergency  
182.7 Medical Services Regulatory Board;

182.8 (12) a hospital administrator of a level III or IV trauma hospital located in a designated  
182.9 rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

182.10 (13) a rehabilitation specialist whose practice includes rehabilitation of patients with  
182.11 major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under  
182.12 section 144.661;

182.13 (14) an attendant or ambulance director who is an EMT, ~~EMT-I~~, or ~~EMT-P~~ AEMT, or  
182.14 paramedic within the meaning of section 144E.001 and who actively practices with a licensed  
182.15 ambulance service in a primary service area located in a designated rural area as defined  
182.16 under section 144.1501, subdivision 1, ~~paragraph (e)~~; and

133.23 (15) the commissioner of public safety or the commissioner's designee.

133.24 Sec. 8. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

133.25 Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state

133.26 commissioner of health finds upon inspection of a facility required to be licensed under the

133.27 provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance

133.28 with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or

133.29 626.557, or the applicable rules promulgated under those sections, a correction order shall

133.30 be issued to the licensee. The correction order shall state the deficiency, cite the specific

133.31 rule violated, and specify the time allowed for correction.

134.1 Sec. 9. **[144.7051] DEFINITIONS.**

134.2 Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7058, the

134.3 terms defined in this section have the meanings given.

134.4 Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a

134.5 standard uniform form developed by the commissioner that may be used by any individual

134.6 to report unsafe staffing situations while maintaining the privacy of patients.

134.7 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

134.8 Subd. 4. **Daily staffing schedule.** "Daily staffing schedule" means the actual number

134.9 of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and

134.10 providing care in that unit during a 24-hour period and the actual number of patients assigned

134.11 to each direct care registered nurse present and providing care in the unit.

134.12 Subd. 5. **Direct-care registered nurse.** "Direct-care registered nurse" means a registered

134.13 nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and

134.14 nonmanagerial and who directly provides nursing care to patients more than 60 percent of

134.15 the time.

134.16 Subd. 6. **Emergency.** "Emergency" means a period when replacement staff are not able

134.17 to report for duty for the next shift or a period of increased patient need because of unusual,

134.18 unpredictable, or unforeseen circumstances, including but not limited to an act of terrorism,

134.19 a disease outbreak, adverse weather conditions, or a natural disaster that impacts continuity

134.20 of patient care.

134.21 Subd. 7. **Hospital.** "Hospital" means any setting that is licensed under this chapter as a

134.22 hospital.

134.23 **EFFECTIVE DATE.** This section is effective July 1, 2025.

134.24 Sec. 10. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEE.**

134.25 Subdivision 1. **Hospital nurse staffing committee required.** (a) Each hospital must

134.26 establish and maintain a functioning hospital nurse staffing committee. A hospital may

134.27 assign the functions and duties of a hospital nurse staffing committee to an existing committee

182.17 (15) the commissioner of public safety or the commissioner's designee.

183.11 Sec. 80. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

183.12 Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state

183.13 commissioner of health finds upon inspection of a facility required to be licensed under the

183.14 provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance

183.15 with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or

183.16 626.557, or the applicable rules promulgated under those sections, a correction order shall

183.17 be issued to the licensee. The correction order shall state the deficiency, cite the specific

183.18 rule violated, and specify the time allowed for correction.

185.15 Sec. 85. **[144.7051] DEFINITIONS.**

185.16 Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7058, the

185.17 terms defined in this section have the meanings given.

185.18 Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a

185.19 standard uniform form developed by the commissioner that may be used by any individual

185.20 to report unsafe staffing situations while maintaining the privacy of patients.

185.21 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

185.22 Subd. 4. **Daily staffing schedule.** "Daily staffing schedule" means the actual number

185.23 of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and

185.24 providing care in that unit during a 24-hour period and the actual number of patients assigned

185.25 to each direct care registered nurse present and providing care in the unit.

185.26 Subd. 5. **Direct-care registered nurse.** "Direct-care registered nurse" means a registered

185.27 nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and

185.28 nonmanagerial and who directly provides nursing care to patients more than 60 percent of

185.29 the time.

185.30 Subd. 6. **Hospital.** "Hospital" means any setting that is licensed under this chapter as a

185.31 hospital.

185.32 **EFFECTIVE DATE.** This section is effective July 1, 2025.

186.1 Sec. 86. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEE.**

186.2 Subdivision 1. **Hospital nurse staffing committee required.** (a) Each hospital must

186.3 establish and maintain a functioning hospital nurse staffing committee. A hospital may

186.4 assign the functions and duties of a hospital nurse staffing committee to an existing committee

134.28 provided the existing committee meets the membership requirements applicable to a hospital  
134.29 nurse staffing committee.

134.30 (b) The commissioner is not required to verify compliance with this section by an on-site  
134.31 visit.

135.1 Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse  
135.2 staffing committee's membership must be direct care registered nurses typically assigned  
135.3 to a specific unit for an entire shift and at least 15 percent of the committee's membership  
135.4 must be other direct care workers typically assigned to a specific unit for an entire shift. A  
135.5 hospital's nurse staffing committee's membership must consist of at least one nurse from  
135.6 each unit covered by the hospital's core staffing plan. Direct care registered nurses and other  
135.7 direct care workers who are members of a collective bargaining unit shall be appointed or  
135.8 elected to the committee according to the guidelines of the applicable collective bargaining  
135.9 agreement. If there is no collective bargaining agreement, direct care registered nurses shall  
135.10 be elected to the committee by direct care registered nurses employed by the hospital and  
135.11 other direct care workers shall be elected to the committee by other direct care workers  
135.12 employed by the hospital.

135.13 (b) The hospital shall appoint 50 percent of the hospital nurse staffing committee's  
135.14 membership.

135.15 Subd. 3. **Staffing committee compensation.** A hospital must treat participation in the  
135.16 hospital nurse staffing committee meetings by any hospital employee as scheduled work  
135.17 time and compensate each committee member at the employee's existing rate of pay. A  
135.18 hospital must relieve all direct care registered nurse members of the hospital nurse staffing  
135.19 committee of other work duties during the times when the committee meets.

135.20 Subd. 4. **Staffing committee meeting frequency.** Each hospital nurse staffing committee  
135.21 must meet at least quarterly.

135.22 Subd. 5. **Staffing committee duties.** (a) Each hospital nurse staffing committee shall  
135.23 create, implement, continuously evaluate, and update as needed evidence-based written  
135.24 core staffing plans to guide the creation of daily staffing schedules for each inpatient care  
135.25 unit of the hospital. Each hospital nurse staffing committee must adopt a core staffing plan  
135.26 annually by a majority vote of all members.

135.27 (b) Each hospital nurse staffing committee must:

135.28 (1) establish a secure, uniform, and easily accessible method for any hospital employee,  
135.29 patient, or patient family member to submit directly to the committee a concern for safe  
135.30 staffing form;

135.31 (2) review each concern for safe staffing form;

135.32 (3) forward a copy of all concern for safe staffing forms to the relevant hospital nurse  
135.33 workload committee;

186.5 provided the existing committee meets the membership requirements applicable to a hospital  
186.6 nurse staffing committee.

186.7 (b) The commissioner is not required to verify compliance with this section by an on-site  
186.8 visit.

186.9 Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse  
186.10 staffing committee's membership must be direct care registered nurses typically assigned  
186.11 to a specific unit for an entire shift and at least 15 percent of the committee's membership  
186.12 must be other direct care workers typically assigned to a specific unit for an entire shift.  
186.13 Direct care registered nurses and other direct care workers who are members of a collective  
186.14 bargaining unit shall be appointed or elected to the committee according to the guidelines  
186.15 of the applicable collective bargaining agreement. If there is no collective bargaining  
186.16 agreement, direct care registered nurses shall be elected to the committee by direct care  
186.17 registered nurses employed by the hospital and other direct care workers shall be elected  
186.18 to the committee by other direct care workers employed by the hospital.

186.19 (b) The hospital shall appoint 50 percent of the hospital nurse staffing committee's  
186.20 membership.

186.21 Subd. 3. **Staffing committee compensation.** A hospital must treat participation in the  
186.22 hospital nurse staffing committee meetings by any hospital employee as scheduled work  
186.23 time and compensate each committee member at the employee's existing rate of pay. A  
186.24 hospital must relieve all direct care registered nurse members of the hospital nurse staffing  
186.25 committee of other work duties during the times when the committee meets.

186.26 Subd. 4. **Staffing committee meeting frequency.** Each hospital nurse staffing committee  
186.27 must meet at least quarterly.

186.28 Subd. 5. **Staffing committee duties.** (a) Each hospital nurse staffing committee shall  
186.29 create, implement, continuously evaluate, and update as needed evidence-based written  
186.30 core staffing plans to guide the creation of daily staffing schedules for each inpatient care  
186.31 unit of the hospital.

186.32 (b) Each hospital nurse staffing committee must:

187.1 (1) establish a secure, uniform, and easily accessible method for any hospital employee,  
187.2 patient, or patient family member to submit directly to the committee a concern for safe  
187.3 staffing form;

187.4 (2) review each concern for safe staffing form;

187.5 (3) forward a copy of all concern for safe staffing forms to the relevant hospital nurse  
187.6 workload committee;

136.1 (4) review the documentation of compliance maintained by the hospital under section  
136.2 144.7056, subdivision 10;

136.3 (5) conduct a trend analysis of the data related to all reported concerns regarding safe  
136.4 staffing;

136.5 (6) develop a mechanism for tracking and analyzing staffing trends within the hospital;

136.6 (7) submit a nurse staffing report to the commissioner;

136.7 (8) assist the commissioner in compiling data for the Nursing Workforce Report by  
136.8 encouraging participation in the commissioner's independent study on reasons licensed  
136.9 registered nurses are leaving the profession; and

136.10 (9) record in the committee minutes for each meeting a summary of the discussions and  
136.11 recommendations of the committee. Each committee must maintain the minutes, records,  
136.12 and distributed materials for five years.

136.13 **EFFECTIVE DATE.** This section is effective July 1, 2025.

136.14 Sec. 11. **[144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.**

136.15 Subdivision 1. **Hospital nurse workload committee required.** (a) Each hospital must  
136.16 establish and maintain functioning hospital nurse workload committees for each unit. **A**  
136.17 **hospital designated as a critical access hospital under section 144.1483, clause (9), may**  
136.18 **assign the functions and duties of its nurse workload committees to the hospital's nurse**  
136.19 **staffing committee.**

136.20 (b) The commissioner is not required to verify compliance with this section by an on-site  
136.21 visit.

136.22 Subd. 2. **Workload committee membership.** (a) At least 35 percent of each workload  
136.23 committee's membership must be direct care registered nurses typically assigned to the unit  
136.24 for an entire shift and at least 15 percent of the committee's membership must be other direct  
136.25 care workers typically assigned to the unit for an entire shift. Direct care registered nurses  
136.26 and other direct care workers who are members of a collective bargaining unit shall be  
136.27 appointed or elected to the committee according to the guidelines of the applicable collective  
136.28 bargaining agreement. If there is no collective bargaining agreement, direct care registered  
136.29 nurses shall be elected to the committee by direct care registered nurses typically assigned  
136.30 to the unit for an entire shift and other direct care workers shall be elected to the committee  
136.31 by other direct care workers typically assigned to the unit for an entire shift.

137.1 (b) The hospital shall appoint 50 percent of each unit's nurse workload committee's  
137.2 membership.

137.3 (c) Notwithstanding paragraphs (a) and (b), if a hospital has established a staffing  
137.4 committee through collective bargaining, the composition of that committee prevails.

187.7 (4) review the documentation of compliance maintained by the hospital under section  
187.8 144.7056, subdivision 10;

187.9 (5) conduct a trend analysis of the data related to all reported concerns regarding safe  
187.10 staffing;

187.11 (6) develop a mechanism for tracking and analyzing staffing trends within the hospital;

187.12 (7) submit a nurse staffing report to the commissioner;

187.13 (8) assist the commissioner in compiling data for the Nursing Workforce Report by  
187.14 encouraging participation in the commissioner's independent study on reasons licensed  
187.15 registered nurses are leaving the profession; and

187.16 (9) record in the committee minutes for each meeting a summary of the discussions and  
187.17 recommendations of the committee. Each committee must maintain the minutes, records,  
187.18 and distributed materials for five years.

187.19 **EFFECTIVE DATE.** This section is effective July 1, 2025.

187.20 Sec. 87. **[144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.**

187.21 Subdivision 1. **Hospital nurse workload committee required.** (a) Each hospital must  
187.22 establish and maintain functioning hospital nurse workload committees for each unit.

187.23 (b) The commissioner is not required to verify compliance with this section by an on-site  
187.24 visit.

187.25 Subd. 2. **Workload committee membership.** (a) At least 35 percent of each workload  
187.26 committee's membership must be direct care registered nurses typically assigned to the unit  
187.27 for an entire shift and at least 15 percent of the committee's membership must be other direct  
187.28 care workers typically assigned to the unit for an entire shift. Direct care registered nurses  
187.29 and other direct care workers who are members of a collective bargaining unit shall be  
187.30 appointed or elected to the committee according to the guidelines of the applicable collective  
187.31 bargaining agreement. If there is no collective bargaining agreement, direct care registered  
188.1 nurses shall be elected to the committee by direct care registered nurses typically assigned  
188.2 to the unit for an entire shift and other direct care workers shall be elected to the committee  
188.3 by other direct care workers typically assigned to the unit for an entire shift.

188.4 (b) The hospital shall appoint 50 percent of each unit's nurse workload committee's  
188.5 membership.

188.6 (c) Notwithstanding paragraphs (a) and (b), if a hospital has established a staffing  
188.7 committee through collective bargaining, **then** the composition of that committee prevails.



137.5 Subd. 3. **Workload committee compensation.** A hospital must treat participation in a  
137.6 hospital nurse workload committee meeting by any hospital employee as scheduled work  
137.7 time and compensate each committee member at the employee's existing rate of pay. A  
137.8 hospital must relieve all direct care registered nurse members of a hospital nurse workload  
137.9 committee of other work duties during the times when the committee meets.

137.10 Subd. 4. **Workload committee meeting frequency.** Each hospital nurse workload  
137.11 committee must meet at least monthly whenever the committee is in receipt of an unresolved  
137.12 concern for safe staffing form.

137.13 Subd. 5. **Workload committee duties.** (a) Each hospital nurse workload committee  
137.14 must create, implement, and maintain dispute resolution procedures to guide the committee's  
137.15 development and implementation of solutions to the staffing concerns raised in concern for  
137.16 safe staffing forms that have been forwarded to the committee. The dispute resolution  
137.17 procedures must include a two-step process. If the nurse workforce committee is not able  
137.18 to implement a solution to the concerns raised in a concern for safe staffing form, the  
137.19 workload committee must refer the matter to the hospital nurse staffing committee within  
137.20 15 calendar days of the events described in the concern for safe staffing form. If after both  
137.21 the nurses and hospitals have attempted in good faith to resolve the concern either side may  
137.22 move forward to an expedited arbitration process with an arbitrator who has expertise in  
137.23 patient care that must be completed within 30 calendar days of the dispute being escalated  
137.24 to the hospital nurse staffing committee.

137.25 (b) In the event both parties believe that they have reached an impasse prior to the 15-  
137.26 or 30-day deadline, the parties may move to the next appropriate step. The committee must  
137.27 use the expedited arbitration process for any complaint that remains unresolved 45 days  
137.28 after the submission of the concern for safe staffing form that gave rise to the complaint.

137.29 (c) Each hospital nurse workload committee must attempt to expeditiously resolve  
137.30 staffing issues the committee determines arise from a violation of the hospital's core staffing  
137.31 plan.

137.32 (d) If the majority of the members of the workload committee agree that the concerns  
137.33 raised can be reasonably grouped together or considered together because multiple forms  
138.1 were submitted from one patient care unit on one date or shift, then the committee can  
138.2 decide to submit them as one occurrence.

138.3 **EFFECTIVE DATE.** This section is effective July 1, 2025.

138.4 Sec. 12. Minnesota Statutes 2022, section 144.7055, is amended to read:

138.5 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

138.6 Subdivision 1. **Definitions.** (a) For the purposes of this section sections 144.7051 to  
138.7 144.7058, the following terms have the meanings given.

188.8 Subd. 3. **Workload committee compensation.** A hospital must treat participation in a  
188.9 hospital nurse workload committee meeting by any hospital employee as scheduled work  
188.10 time and compensate each committee member at the employee's existing rate of pay. A  
188.11 hospital must relieve all direct care registered nurse members of a hospital nurse workload  
188.12 committee of other work duties during the times when the committee meets.

188.13 Subd. 4. **Workload committee meeting frequency.** Each hospital nurse workload  
188.14 committee must meet at least monthly whenever the committee is in receipt of an unresolved  
188.15 concern for safe staffing form.

188.16 Subd. 5. **Workload committee duties.** (a) Each hospital nurse workload committee  
188.17 must create, implement, and maintain dispute resolution procedures to guide the committee's  
188.18 development and implementation of solutions to the staffing concerns raised in concern for  
188.19 safe staffing forms that have been forwarded to the committee. The dispute resolution  
188.20 procedures must include an expedited arbitration process with an arbitrator who has expertise  
188.21 in patient care. The committee must use the expedited arbitration process for any complaint  
188.22 that remains unresolved 30 days after the submission of the concern for safe staffing form  
188.23 that gave rise to the complaint.

188.24 (b) Each hospital nurse workload committee must attempt to expeditiously resolve  
188.25 staffing issues the committee determines arise from a violation of the hospital's core staffing  
188.26 plan.

188.27 **EFFECTIVE DATE.** This section is effective July 1, 2025.

188.28 Sec. 88. Minnesota Statutes 2022, section 144.7055, is amended to read:

188.29 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

188.30 Subdivision 1. **Definitions.** (a) For the purposes of this section sections 144.7051 to  
188.31 144.7058, the following terms have the meanings given.

138.8 (b) "Core staffing plan" means the projected number of full-time equivalent  
138.9 nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit  
138.10 a plan described in subdivision 2.

138.11 (c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and  
138.12 other health care workers, which may include but is not limited to nursing assistants, nursing  
138.13 aides, patient care technicians, and patient care assistants, who perform nonmanagerial  
138.14 direct patient care functions for more than 50 percent of their scheduled hours on a given  
138.15 patient care unit.

138.16 (d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients  
138.17 and staff for which a distinct staffing plan daily staffing schedule exists and that operates  
138.18 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not  
138.19 include any hospital-based clinic, long-term care facility, or outpatient hospital department.

138.20 (e) "Staffing hours per patient day" means the number of full-time equivalent  
138.21 nonmanagerial care staff who will ordinarily be assigned to provide direct patient care  
138.22 divided by the expected average number of patients upon which such assignments are based.

138.23 (f) "Patient acuity tool" means a system for measuring an individual patient's need for  
138.24 nursing care. This includes utilizing a professional registered nursing assessment of patient  
138.25 condition to assess staffing need.

138.26 Subd. 2. **Hospital core staffing report plans.** (a) The chief nursing executive or nursing  
138.27 designee hospital nurse staffing committee of every reporting hospital in Minnesota under  
138.28 section 144.50 will must develop a core staffing plan for each patient inpatient care unit.

138.29 (b) The commissioner is not required to verify compliance with this section by an on-site  
138.30 visit.

138.31 ~~(b)~~ (c) Core staffing plans ~~shall~~ must specify all of the following:

139.1 (1) the projected number of full-time equivalent for nonmanagerial care staff that will  
139.2 be assigned in a 24-hour period to each patient inpatient care unit for each 24-hour period;

139.3 (2) the maximum number of patients on each inpatient care unit for whom a direct care  
139.4 nurse can typically safely care;

139.5 (3) criteria for determining when circumstances exist on each inpatient care unit such  
139.6 that a direct care nurse cannot safely care for the typical number of patients and when  
139.7 assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

139.8 (4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing  
139.9 levels when such adjustments are required by patient acuity and nursing intensity in the  
139.10 unit;

139.11 (5) a contingency plan for each inpatient unit to safely address circumstances in which  
139.12 patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing

189.1 (b) "Core staffing plan" means the projected number of full-time equivalent  
189.2 nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit  
189.3 a plan described in subdivision 2.

189.4 (c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and  
189.5 other health care workers, which may include but is not limited to nursing assistants, nursing  
189.6 aides, patient care technicians, and patient care assistants, who perform nonmanagerial  
189.7 direct patient care functions for more than 50 percent of their scheduled hours on a given  
189.8 patient care unit.

189.9 (d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients  
189.10 and staff for which a distinct staffing plan daily staffing schedule exists and that operates  
189.11 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not  
189.12 include any hospital-based clinic, long-term care facility, or outpatient hospital department.

189.13 (e) "Staffing hours per patient day" means the number of full-time equivalent  
189.14 nonmanagerial care staff who will ordinarily be assigned to provide direct patient care  
189.15 divided by the expected average number of patients upon which such assignments are based.

189.16 (f) "Patient acuity tool" means a system for measuring an individual patient's need for  
189.17 nursing care. This includes utilizing a professional registered nursing assessment of patient  
189.18 condition to assess staffing need.

189.19 Subd. 2. **Hospital core staffing report plans.** (a) The chief nursing executive or nursing  
189.20 designee hospital nurse staffing committee of every reporting hospital in Minnesota under  
189.21 section 144.50 will must develop a core staffing plan for each patient inpatient care unit.

189.22 (b) The commissioner is not required to verify compliance with this section by an on-site  
189.23 visit.

189.24 ~~(b)~~ (c) Core staffing plans ~~shall~~ must specify all of the following:

189.25 (1) the projected number of full-time equivalent for nonmanagerial care staff that will  
189.26 be assigned in a 24-hour period to each patient inpatient care unit for each 24-hour period;

189.27 (2) the maximum number of patients on each inpatient care unit for whom a direct care  
189.28 nurse can typically safely care;

189.29 (3) criteria for determining when circumstances exist on each inpatient care unit such  
189.30 that a direct care nurse cannot safely care for the typical number of patients and when  
189.31 assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

190.1 (4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing  
190.2 levels when such adjustments are required by patient acuity and nursing intensity in the  
190.3 unit;

190.4 (5) a contingency plan for each inpatient unit to safely address circumstances in which  
190.5 patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing

139.13 schedule. A contingency plan must include a method to quickly identify, for each daily  
139.14 staffing schedule, additional direct care registered nurses who are available to provide direct  
139.15 care on the inpatient care unit;

139.16 (6) strategies to enable direct care registered nurses to take breaks they are entitled to  
139.17 under law or under an applicable collective bargaining agreement; and

139.18 (7) strategies to eliminate patient boarding in emergency departments that do not rely  
139.19 on requiring direct care registered nurses to work additional hours to provide care.

139.20 (d) Core staffing plans must ensure that:

139.21 (1) the person creating a daily staffing schedule has sufficiently detailed information to  
139.22 create a daily staffing schedule that meets the requirements of the plan;

139.23 (2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff  
139.24 to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive  
139.25 24-hour periods requiring 16 or more hours;

139.26 (3) a direct care registered nurse is not required or expected to perform functions outside  
139.27 the nurse's professional license;

139.28 (4) a light duty direct care registered nurse is given appropriate assignments;

139.29 (5) a charge nurse does not have patient assignments; and

139.30 (6) daily staffing schedules do not interfere with applicable collective bargaining  
139.31 agreements.

140.1 Subd. 2a. **Development of hospital core staffing plans.** (a) Prior to ~~submitting~~  
140.2 ~~completing or updating the core staffing plan, as required in subdivision 3, hospitals shall~~  
140.3 a hospital nurse staffing committee must consult with representatives of the hospital medical  
140.4 staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about  
140.5 the core staffing plan and the expected average number of patients upon which the core  
140.6 staffing plan is based.

140.7 (b) When developing a core staffing plan, a hospital nurse staffing committee must  
140.8 consider all of the following:

140.9 (1) the individual needs and expected census of each inpatient care unit;

140.10 (2) unit-specific patient acuity, including fall risk and behaviors requiring intervention,  
140.11 such as physical aggression toward self or others or destruction of property;

140.12 (3) unit-specific demands on direct care registered nurses' time, including: frequency of  
140.13 admissions, discharges, and transfers; frequency and complexity of patient evaluations and  
140.14 assessments; frequency and complexity of nursing care planning; planning for patient

190.6 schedule. A contingency plan must include a method to quickly identify, for each daily  
190.7 staffing schedule, additional direct care registered nurses who are available to provide direct  
190.8 care on the inpatient care unit;

190.9 (6) strategies to enable direct care registered nurses to take breaks they are entitled to  
190.10 under law or under an applicable collective bargaining agreement; and

190.11 (7) strategies to eliminate patient boarding in emergency departments that do not rely  
190.12 on requiring direct care registered nurses to work additional hours to provide care.

190.13 (d) Core staffing plans must ensure that:

190.14 (1) the person creating a daily staffing schedule has sufficiently detailed information to  
190.15 create a daily staffing schedule that meets the requirements of the plan;

190.16 (2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff  
190.17 to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive  
190.18 24-hour periods requiring 16 or more hours;

190.19 (3) a direct care registered nurse is not required or expected to perform functions outside  
190.20 the nurse's professional license;

190.21 (4) a light duty direct care registered nurse is given appropriate assignments;

190.22 (5) a charge nurse does not have patient assignments; and

190.23 (6) daily staffing schedules do not interfere with applicable collective bargaining  
190.24 agreements.

190.25 Subd. 2a. **Development of hospital core staffing plans.** (a) Prior to ~~submitting~~  
190.26 ~~completing or updating the core staffing plan, as required in subdivision 3, hospitals shall~~  
190.27 a hospital nurse staffing committee must consult with representatives of the hospital medical  
190.28 staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about  
190.29 the core staffing plan and the expected average number of patients upon which the core  
190.30 staffing plan is based.

190.31 (b) When developing a core staffing plan, a hospital nurse staffing committee must  
190.32 consider all of the following:

191.1 (1) the individual needs and expected census of each inpatient care unit;

191.2 (2) unit-specific patient acuity, including fall risk and behaviors requiring intervention,  
191.3 such as physical aggression toward self or others or destruction of property;

191.4 (3) unit-specific demands on direct care registered nurses' time, including: frequency of  
191.5 admissions, discharges, and transfers; frequency and complexity of patient evaluations and  
191.6 assessments; frequency and complexity of nursing care planning; planning for patient

140.15 discharge; assessing for patient referral; patient education; and implementing infectious  
140.16 disease protocols;

140.17 (4) the architecture and geography of the inpatient care unit, including the placement of  
140.18 patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

140.19 (5) mechanisms and procedures to provide for one-to-one patient observation for patients  
140.20 on psychiatric or other units;

140.21 (6) the stress that direct-care nurses experience when required to work extreme amounts  
140.22 of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

140.23 (7) the need for specialized equipment and technology on the unit;

140.24 (8) other special characteristics of the unit or community patient population, including  
140.25 age, cultural and linguistic diversity and needs, functional ability, communication skills,  
140.26 and other relevant social and socioeconomic factors;

140.27 (9) the skill mix of personnel other than direct care registered nurses providing or  
140.28 supporting direct patient care on the unit;

140.29 (10) mechanisms and procedures for identifying additional registered nurses who are  
140.30 available for direct patient care when patients' unexpected needs exceed the planned workload  
140.31 for direct care staff; and

141.1 (11) demands on direct care registered nurses' time not directly related to providing  
141.2 direct care on a unit, such as involvement in quality improvement activities, professional  
141.3 development, service to the hospital, including serving on the hospital nurse staffing  
141.4 committee or the hospital nurse workload committee, and service to the profession.

141.5 Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing  
141.6 committee cannot approve a hospital core staffing plan by a majority vote, the members of  
141.7 the nurse staffing committee must enter an expedited arbitration process with an arbitrator  
141.8 who understands patient care needs.

141.9 Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects  
141.10 to a core staffing plan approved by a majority vote of the hospital nurse staffing committee,  
141.11 the hospital may elect to attempt to amend the core staffing plan through arbitration.

141.12 (b) During an ongoing dispute resolution process, a hospital must continue to implement  
141.13 the core staffing plan as written and approved by the hospital nurse staffing committee.

141.14 (c) If the dispute resolution process results in an amendment to the core staffing plan,  
141.15 the hospital must implement the amended core staffing plan.

141.16 Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital  
141.17 must submit to the commissioner the core staffing plans approved by the hospital's nurse  
141.18 staffing committee. A hospital must submit any substantial updates to any previously

191.7 discharge; assessing for patient referral; patient education; and implementing infectious  
191.8 disease protocols;

191.9 (4) the architecture and geography of the inpatient care unit, including the placement of  
191.10 patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

191.11 (5) mechanisms and procedures to provide for one-to-one patient observation for patients  
191.12 on psychiatric or other units;

191.13 (6) the stress that direct-care nurses experience when required to work extreme amounts  
191.14 of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

191.15 (7) the need for specialized equipment and technology on the unit;

191.16 (8) other special characteristics of the unit or community patient population, including  
191.17 age, cultural and linguistic diversity and needs, functional ability, communication skills,  
191.18 and other relevant social and socioeconomic factors;

191.19 (9) the skill mix of personnel other than direct care registered nurses providing or  
191.20 supporting direct patient care on the unit;

191.21 (10) mechanisms and procedures for identifying additional registered nurses who are  
191.22 available for direct patient care when patients' unexpected needs exceed the planned workload  
191.23 for direct care staff; and

191.24 (11) demands on direct care registered nurses' time not directly related to providing  
191.25 direct care on a unit, such as involvement in quality improvement activities, professional  
191.26 development, service to the hospital, including serving on the hospital nurse staffing  
191.27 committee or the hospital nurse workload committee, and service to the profession.

191.28 Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing  
191.29 committee cannot approve a hospital core staffing plan by a majority vote, the members of  
191.30 the nurse staffing committee must enter an expedited arbitration process with an arbitrator  
191.31 who understands patient care needs.

192.1 Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects  
192.2 to a core staffing plan approved by a majority vote of the hospital nurse staffing committee,  
192.3 the hospital may elect to attempt to amend the core staffing plan through arbitration.

192.4 (b) During an ongoing dispute resolution process, a hospital must continue to implement  
192.5 the core staffing plan as written and approved by the hospital nurse staffing committee.

192.6 (c) If the dispute resolution process results in an amendment to the core staffing plan,  
192.7 the hospital must implement the amended core staffing plan.

192.8 Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital  
192.9 must submit to the commissioner the core staffing plans approved by the hospital's nurse  
192.10 staffing committee. A hospital must submit any substantial updates to any previously

141.19 approved plan, including any amendments to the plan resulting from arbitration, within 30  
141.20 calendar days of approval of the update by the committee or the conclusion of arbitration.

141.21 Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core  
141.22 staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota  
141.23 Hospital Association shall include each reporting hospital's core staffing plan on the  
141.24 Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,  
141.25 2014. any substantial changes to the core staffing plan shall be updated within 30 days.

141.26 (b) The Minnesota Hospital Association shall include on its website for each reporting  
141.27 hospital on a quarterly basis the actual direct patient care hours per patient and per unit.  
141.28 Hospitals must submit the direct patient care report to the Minnesota Hospital Association  
141.29 by July 1, 2014, and quarterly thereafter.

141.30 **EFFECTIVE DATE.** This section is effective July 1, 2025.

142.1 Sec. 13. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

142.2 Subdivision 1. **Plan implementation required.** (a) A hospital must implement the core  
142.3 staffing plans approved annually by a majority vote of its hospital nurse staffing committee.  
142.4 Nothing in sections 144.7051 to 144.7058 relieves the chief nursing executive of a hospital  
142.5 from fulfilling the chief nursing executive's duties under Code of Federal Regulations, title  
142.6 42, section 482.23. If at any time the chief nursing executive believes the types and numbers  
142.7 of nursing personnel and staff required under the hospital's core staffing plan are insufficient  
142.8 to provide nursing care for a unit in the hospital, the chief nursing executive may increase  
142.9 the staffing on that unit beyond the levels required by the plan.

142.10 (b) A core staffing plan does not apply during an emergency and a hospital is not out of  
142.11 compliance with its core staffing plan during an emergency. A nurse may be required to  
142.12 accept an additional patient assignment in an emergency.

142.13 (c) The commissioner is required to verify compliance with this section by on-site visits  
142.14 during routine hospital surveys.

142.15 Subd. 2. **Public posting of core staffing plans.** A hospital must post its core staffing  
142.16 plan for each inpatient care unit in a public area on the relevant unit.

142.17 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing  
142.18 plan, a hospital must post a notice stating whether the current staffing on the unit complies  
142.19 with the hospital's core staffing plan for that unit. The public notice of compliance must  
142.20 include a list of the number of nonmanagerial care staff working on the unit during the  
142.21 current shift and the number of patients assigned to each direct care registered nurse working  
142.22 on the unit during the current shift. The list must enumerate the nonmanagerial care staff  
142.23 by health care worker type. The public notice of compliance must be posted immediately  
142.24 adjacent to the publicly posted core staffing plan.

192.11 approved plan, including any amendments to the plan resulting from arbitration, within 30  
192.12 calendar days of approval of the update by the committee or the conclusion of arbitration.

192.13 Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core  
192.14 staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota  
192.15 Hospital Association shall include each reporting hospital's core staffing plan on the  
192.16 Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,  
192.17 2014. any substantial changes to the core staffing plan shall be updated within 30 days.

192.18 (b) The Minnesota Hospital Association shall include on its website for each reporting  
192.19 hospital on a quarterly basis the actual direct patient care hours per patient and per unit.  
192.20 Hospitals must submit the direct patient care report to the Minnesota Hospital Association  
192.21 by July 1, 2014, and quarterly thereafter.

192.22 **EFFECTIVE DATE.** This section is effective July 1, 2025.

192.23 Sec. 89. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

192.24 Subdivision 1. **Plan implementation required.** (a) A hospital must implement the core  
192.25 staffing plans approved by a majority vote of its hospital nurse staffing committee.

192.26 (b) The commissioner is not required to verify compliance with this section by on-site  
192.27 visits during routine hospital surveys.

192.28 Subd. 2. **Public posting of core staffing plans.** A hospital must post its core staffing  
192.29 plan for each inpatient care unit in a public area on the relevant unit.

192.30 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing  
192.31 plan, a hospital must post a notice stating whether the current staffing on the unit complies  
192.32 with the hospital's core staffing plan for that unit. The public notice of compliance must  
193.1 include a list of the number of nonmanagerial care staff working on the unit during the  
193.2 current shift and the number of patients assigned to each direct care registered nurse working  
193.3 on the unit during the current shift. The list must enumerate the nonmanagerial care staff  
193.4 by health care worker type. The public notice of compliance must be posted immediately  
193.5 adjacent to the publicly posted core staffing plan.

193.6 Subd. 4. **Posting of compliance in patient rooms.** A hospital must post on a whiteboard  
193.7 in a patient's room or make available through a television in a patient's room both the number

142.25 Subd. 4. **Public posting of emergency department wait times.** A hospital must maintain  
142.26 on its website and publicly display in its emergency department the approximate wait time  
142.27 for patients who are not in critical need of emergency care. The approximate wait time must  
142.28 be updated at least hourly.

142.29 Subd. 5. **Public distribution of core staffing plan and notice of compliance.** (a) A  
142.30 hospital must include with the posted materials described in subdivisions 2 and 3 a statement  
142.31 that individual copies of the posted materials are available upon request to any patient on  
142.32 the unit, visitor of a patient on the unit, or prospective patient. The statement must include  
142.33 specific instructions for obtaining copies of the posted materials.

143.1 (b) A hospital must, within four hours after the request, provide individual copies of all  
143.2 the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any  
143.3 visitor of a patient on the unit who requests the materials.

143.4 Subd. 6. **Reporting noncompliance.** (a) Any hospital employee, patient, or patient  
143.5 family member may submit a concern for safe staffing form to report an instance of  
143.6 noncompliance with a hospital's core staffing plan, to object to the contents of a core staffing  
143.7 plan, or to challenge the process of the hospital nurse staffing committee.

143.8 (b) A hospital must not interfere with or retaliate against a hospital employee for  
143.9 submitting a concern for safe staffing form.

143.10 (c) The commissioner of labor and industry may investigate any report of interference  
143.11 with or retaliation against a hospital employee for submitting a concern for safe staffing  
143.12 form. The commissioner of labor and industry may fine a hospital up to \$250,000 if the  
143.13 commissioner finds the hospital interfered with or retaliated against a hospital employee  
143.14 for submitting a concern for safe staffing form.

143.15 Subd. 7. **Documentation of compliance.** Each hospital must document compliance with  
143.16 its core nursing plans and maintain records demonstrating compliance for each inpatient  
143.17 care unit for five years. Each hospital must provide to its nurse staffing committee access  
143.18 to all documentation required under this subdivision.

193.8 of patients a nurse on the patient's unit should be assigned under the relevant core staffing  
193.9 plan and the number of patients actually assigned to a nurse during the current shift.

193.10 Subd. 5. **Deviations from core staffing plans.** (a) Before hospital management lowers  
193.11 the staffing level of any unit, management must consult with and receive agreement from  
193.12 at least 50 percent of the direct care registered nurses staffing the unit.

193.13 (b) Deviation from a core staffing plan with the agreement of at least 50 percent of the  
193.14 direct care registered nurses staffing the unit does not constitute compliance with the core  
193.15 staffing plan.

193.16 Subd. 6. **Public posting of emergency department wait times.** A hospital must maintain  
193.17 on its website and publicly display in its emergency department the approximate wait time  
193.18 for patients who are not in critical need of emergency care. The approximate wait time must  
193.19 be updated at least hourly.

193.20 Subd. 7. **Disclosure of staffing plan upon admission.** A hospital must provide an  
193.21 explanation of its core staffing plan to each patient upon admission.

193.22 Subd. 8. **Public distribution of core staffing plan and notice of compliance.** (a) A  
193.23 hospital must include with the posted materials described in subdivisions 2 and 3 a statement  
193.24 that individual copies of the posted materials are available upon request to any patient on  
193.25 the unit or to any visitor of a patient on the unit. The statement must include specific  
193.26 instructions for obtaining copies of the posted materials.

193.27 (b) A hospital must, within four hours after the request, provide individual copies of all  
193.28 the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any  
193.29 visitor of a patient on the unit who requests the materials.

193.30 Subd. 9. **Reporting noncompliance.** (a) Any hospital employee, patient, or patient  
193.31 family member may submit a concern for safe staffing form to report an instance of  
193.32 noncompliance with a hospital's core staffing plan, to object to the contents of a core staffing  
193.33 plan, or to challenge the process of the hospital nurse staffing committee.

194.1 (b) A hospital must not interfere with or retaliate against a hospital employee for  
194.2 submitting a concern for safe staffing form.

194.3 (c) The commissioner of labor and industry may investigate any report of retaliation  
194.4 against a hospital employee for submitting a concern for safe staffing form. The commissioner  
194.5 of labor and industry may fine a hospital up to \$250,000 for each instance of substantiated  
194.6 retaliation against a hospital employee for submitting a concern for safe staffing form.

194.7 Subd. 10. **Documentation of compliance.** Each hospital must document compliance  
194.8 with its core nursing plans and maintain records demonstrating compliance for each inpatient  
194.9 care unit for five years. Each hospital must provide to its nurse staffing committee access  
194.10 to all documentation required under this subdivision.

143.19 **EFFECTIVE DATE.** This section is effective October 1, 2025.

143.20 Sec. 14. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

143.21 Subdivision 1. **Nurse staffing report required.** Each hospital nurse staffing committee

143.22 must submit quarterly nurse staffing reports to the commissioner. Reports must be submitted

143.23 within 60 days of the end of the quarter.

143.24 Subd. 2. **Nurse staffing report.** Nurse staffing reports submitted to the commissioner

143.25 by a hospital nurse staffing committee must:

143.26 (1) identify any suspected incidents of the hospital failing during the reporting quarter

143.27 to meet the standards of one of its core staffing plans;

143.28 (2) identify each occurrence of the hospital accepting an elective surgery at a time when

143.29 the unit performing the surgery is out of compliance with its core staffing plan;

143.30 (3) identify problems of insufficient staffing, including but not limited to:

143.31 (i) inappropriate number of direct care registered nurses scheduled in a unit;

144.1 (ii) inappropriate number of direct care registered nurses present and delivering care in

144.2 a unit;

144.3 (iii) inappropriately experienced direct care registered nurses scheduled for a particular

144.4 unit;

144.5 (iv) inappropriately experienced direct care registered nurses present and delivering care

144.6 in a unit;

144.7 (v) inability for nurse supervisors to adjust daily nursing schedules for increased patient

144.8 acuity or nursing intensity in a unit; and

144.9 (vi) chronically unfilled direct care positions within the hospital;

144.10 (4) identify any units that pose a risk to patient safety due to inadequate staffing;

144.11 (5) propose solutions to solve insufficient staffing;

144.12 (6) propose solutions to reduce risks to patient safety in inadequately staffed units; and

144.13 (7) describe staffing trends within the hospital.

144.14 Subd. 3. **Public posting of nurse staffing reports.** The commissioner must include on

144.15 its website each quarterly nurse staffing report submitted to the commissioner under

144.16 subdivision 1.

144.17 Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each

144.18 hospital nurse staffing committee a uniform format or standard form the committee must

144.19 use to comply with the nurse staffing reporting requirements under this section. The format

144.20 or form developed by the commissioner must present the reported information in a manner

194.11 **EFFECTIVE DATE.** This section is effective October 1, 2025.

194.12 Sec. 90. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

194.13 Subdivision 1. **Nurse staffing report required.** Each hospital nurse staffing committee

194.14 must submit quarterly nurse staffing reports to the commissioner. Reports must be submitted

194.15 within 60 days of the end of the quarter.

194.16 Subd. 2. **Nurse staffing report.** Nurse staffing reports submitted to the commissioner

194.17 by a hospital nurse staffing committee must:

194.18 (1) identify any suspected incidents of the hospital failing during the reporting quarter

194.19 to meet the standards of one of its core staffing plans;

194.20 (2) identify each occurrence of the hospital accepting an elective surgery at a time when

194.21 the unit performing the surgery is out of compliance with its core staffing plan;

194.22 (3) identify problems of insufficient staffing, including but not limited to:

194.23 (i) inappropriate number of direct care registered nurses scheduled in a unit;

194.24 (ii) inappropriate number of direct care registered nurses present and delivering care in

194.25 a unit;

194.26 (iii) inappropriately experienced direct care registered nurses scheduled for a particular

194.27 unit;

194.28 (iv) inappropriately experienced direct care registered nurses present and delivering care

194.29 in a unit;

194.30 (v) inability for nurse supervisors to adjust daily nursing schedules for increased patient

194.31 acuity or nursing intensity in a unit; and

195.1 (vi) chronically unfilled direct care positions within the hospital;

195.2 (4) identify any units that pose a risk to patient safety due to inadequate staffing;

195.3 (5) propose solutions to solve insufficient staffing;

195.4 (6) propose solutions to reduce risks to patient safety in inadequately staffed units; and

195.5 (7) describe staffing trends within the hospital.

195.6 Subd. 3. **Public posting of nurse staffing reports.** The commissioner must include on

195.7 its website each quarterly nurse staffing report submitted to the commissioner under

195.8 subdivision 1.

195.9 Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each

195.10 hospital nurse staffing committee a uniform format or standard form the committee must

195.11 use to comply with the nurse staffing reporting requirements under this section. The format

195.12 or form developed by the commissioner must present the reported information in a manner



144.21 allowing patients and the public to clearly understand and compare staffing patterns and  
144.22 actual levels of staffing across reporting hospitals. The commissioner must include, in the  
144.23 uniform format or on the standardized form, space to allow the reporting hospital to include  
144.24 a description of additional resources available to support unit-level patient care and a  
144.25 description of the hospital.

144.26 Subd. 5. **Penalties.** Notwithstanding section 144.653, subdivisions 5 and 6, the  
144.27 commissioner may impose an immediate fine of up to \$5,000 for each instance of a failure  
144.28 to report an elective surgery requiring reporting under subdivision 2, clause (2). The facility  
144.29 may request a hearing on the immediate fine under section 144.653, subdivision 8.

144.30 **EFFECTIVE DATE.** This section is effective October 1, 2025.

145.1 Sec. 15. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

145.2 Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the  
145.3 commissioner must develop a uniform annual grading system that evaluates each hospital's  
145.4 compliance with its own core staffing plan. The commissioner must assign each hospital a  
145.5 compliance grade based on a review of the hospital's nurse staffing report submitted under  
145.6 section 144.7057. The commissioner must assign a failing compliance grade to any hospital  
145.7 that has not been in compliance with its staffing plan for six or more months during the  
145.8 reporting year.

145.9 Subd. 2. **Grading factors.** When grading a hospital's compliance with its core staffing  
145.10 plan, the commissioner must consider at least the following factors:

145.11 (1) the number of assaults and injuries occurring in the hospital involving patients;

145.12 (2) the prevalence of infections, pressure ulcers, and falls among patients;

145.13 (3) emergency department wait times;

145.14 (4) readmissions;

145.15 (5) use of restraints and other behavior interventions;

145.16 (6) employment turnover rates among direct care registered nurses and other direct care  
145.17 health care workers;

145.18 (7) except in instances when nurses volunteer for overtime, prevalence of overtime  
145.19 among direct care registered nurses and other direct care health care workers;

145.20 (8) prevalence of missed shift breaks among direct care registered nurses and other direct  
145.21 care health care workers;

145.22 (9) frequency of incidents of being out of compliance with a core staffing plan;

145.23 (10) the extent of noncompliance with a core staffing plan; and

195.13 allowing patients and the public to clearly understand and compare staffing patterns and  
195.14 actual levels of staffing across reporting hospitals. The commissioner must include, in the  
195.15 uniform format or on the standardized form, space to allow the reporting hospital to include  
195.16 a description of additional resources available to support unit-level patient care and a  
195.17 description of the hospital.

195.18 Subd. 5. **Penalties.** Notwithstanding section 144.653, subdivisions 5 and 6, the  
195.19 commissioner may impose an immediate fine of up to \$5,000 for each instance of a failure  
195.20 to report an elective surgery requiring reporting under subdivision 2, clause (2). The facility  
195.21 may request a hearing on the immediate fine under section 144.653, subdivision 8.

195.22 **EFFECTIVE DATE.** This section is effective October 1, 2025.

195.23 Sec. 91. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

195.24 Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the  
195.25 commissioner must develop a uniform annual grading system that evaluates each hospital's  
195.26 compliance with its own core staffing plan. The commissioner must assign each hospital a  
195.27 compliance grade based on a review of the hospital's nurse staffing report submitted under  
195.28 section 144.7057. The commissioner must assign a failing compliance grade to any hospital  
195.29 that has not been in compliance with its staffing plan for six or more months during the  
195.30 reporting year.

195.31 Subd. 2. **Grading factors.** When grading a hospital's compliance with its core staffing  
195.32 plan, the commissioner must consider at least the following factors:

196.1 (1) the number of assaults and injuries occurring in the hospital involving patients;

196.2 (2) the prevalence of infections, pressure ulcers, and falls among patients;

196.3 (3) emergency department wait times;

196.4 (4) readmissions;

196.5 (5) use of restraints and other behavior interventions;

196.6 (6) employment turnover rates among direct care registered nurses and other direct care  
196.7 health care workers;

196.8 (7) prevalence of overtime among direct care registered nurses and other direct care  
196.9 health care workers;

196.10 (8) prevalence of missed shift breaks among direct care registered nurses and other direct  
196.11 care health care workers;

196.12 (9) frequency of incidents of being out of compliance with a core staffing plan; and

196.13 (10) the extent of noncompliance with a core staffing plan.

145.24 (11) number of inpatient psychiatric units.

145.25 Subd. 3. **Public disclosure of compliance grades.** Beginning January 1, 2027, the  
145.26 commissioner must publish a compliance grade for each hospital on the department website  
145.27 with a link to the hospital's core staffing plan, the hospital's nurse staffing reports, and an  
145.28 accessible and easily understandable explanation of what the compliance grade means.

145.29 **EFFECTIVE DATE.** This section is effective January 1, 2026.

146.1 Sec. 16. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

146.2 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
146.3 the meanings given.

146.4 (b) "Emergency" means a period when replacement staff are not able to report for duty  
146.5 for the next shift, or a period of increased patient need, because of unusual, unpredictable,  
146.6 or unforeseen circumstances, including but not limited to an act of terrorism, a disease  
146.7 outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient  
146.8 care.

146.9 (c) "Nurse" has the meaning given in section 148.171, subdivision 9, and includes nurses  
146.10 employed by the state.

146.11 (d) "Taking action against" means discharging, disciplining, threatening, reporting to  
146.12 the Board of Nursing, discriminating against, or penalizing regarding compensation, terms,  
146.13 conditions, location, or privileges of employment.

146.14 Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other  
146.15 entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility  
146.16 licensed by the commissioner of health, and the facility's agent, is prohibited from taking  
146.17 action against a nurse solely on the ground that the nurse fails to accept an assignment of  
146.18 one or more additional patients because the nurse reasonably determines that accepting an  
146.19 additional patient assignment may create an unnecessary danger to a patient's life, health,  
146.20 or safety or may otherwise constitute a ground for disciplinary action under section 148.261.  
146.21 This subdivision does not apply to a nursing facility, an intermediate care facility for persons  
146.22 with developmental disabilities, or a licensed boarding care home.

146.23 Subd. 3. **State nurses.** Subdivision 2 applies to nurses employed by the state regardless  
146.24 of the type of facility where the nurse is employed and regardless of the facility's license,  
146.25 if the nurse is involved in resident or patient care.

146.26 Subd. 4. **Collective bargaining rights.** This section does not diminish or impair the  
146.27 rights of a person under any collective bargaining agreement.

146.28 Subd. 5. **Emergency.** A nurse may be required to accept an additional patient assignment  
146.29 in an emergency.

196.14 Subd. 3. **Public disclosure of compliance grades.** Beginning January 1, 2027, the  
196.15 commissioner must publish a compliance grade for each hospital on the department website  
196.16 with a link to the hospital's core staffing plan, the hospital's nurse staffing reports, and an  
196.17 accessible and easily understandable explanation of what the compliance grade means.

196.18 **EFFECTIVE DATE.** This section is effective January 1, 2026.

196.19 Sec. 92. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

196.20 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
196.21 the meanings given.

196.22 (b) "Emergency" means a period when replacement staff are not able to report for duty  
196.23 for the next shift, or a period of increased patient need, because of unusual, unpredictable,  
196.24 or unforeseen circumstances, including but not limited to an act of terrorism, a disease  
196.25 outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient  
196.26 care.

196.27 (c) "Nurse" has the meaning given in section 148.171, subdivision 9, and includes nurses  
196.28 employed by the state.

197.1 (d) "Taking action against" means discharging, disciplining, threatening, reporting to  
197.2 the Board of Nursing, discriminating against, or penalizing regarding compensation, terms,  
197.3 conditions, location, or privileges of employment.

197.4 Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other  
197.5 entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility  
197.6 licensed by the commissioner of health, and the facility's agent, is prohibited from taking  
197.7 action against a nurse solely on the ground that the nurse fails to accept an assignment of  
197.8 one or more additional patients because the nurse determines that accepting an additional  
197.9 patient assignment, in the nurse's judgment, may create an unnecessary danger to a patient's  
197.10 life, health, or safety or may otherwise constitute a ground for disciplinary action under  
197.11 section 148.261. This subdivision does not apply to a nursing facility, an intermediate care  
197.12 facility for persons with developmental disabilities, or a licensed boarding care home.

197.13 Subd. 3. **State nurses.** Subdivision 2 applies to nurses employed by the state regardless  
197.14 of the type of facility where the nurse is employed and regardless of the facility's license,  
197.15 if the nurse is involved in resident or patient care.

197.16 Subd. 4. **Collective bargaining rights.** This section does not diminish or impair the  
197.17 rights of a person under any collective bargaining agreement.

197.18 Subd. 5. **Emergency.** A nurse may be required to accept an additional patient assignment  
197.19 in an emergency.

146.30 Subd. 6. **Enforcement.** The commissioner of labor and industry may enforce this section  
146.31 by issuing a compliance order under section 177.27, subdivision 4. The commissioner of  
146.32 labor and industry may assess a fine of up to \$5,000 for each violation of this section.

147.1 Sec. 17. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

147.2 Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish  
147.3 an adverse health event reporting system designed to facilitate quality improvement in the  
147.4 health care system. The reporting system shall not be designed to punish errors by health  
147.5 care practitioners or health care facility employees.

147.6 (b) The reporting system shall consist of:

147.7 (1) mandatory reporting by facilities of 27 adverse health care events;

147.8 (2) mandatory reporting by facilities of whether the unit where an adverse event occurred  
147.9 was in compliance with the core staffing plan for the unit at the time of the adverse event;

147.10 (3) mandatory completion of a root cause analysis and a corrective action plan by the  
147.11 facility and reporting of the findings of the analysis and the plan to the commissioner or  
147.12 reporting of reasons for not taking corrective action;

147.13 ~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of  
147.14 systemic failure in the health care system and successful methods to correct these failures;

147.15 ~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system  
147.16 requirements; and

147.17 ~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and  
147.18 the public to maximize the use of the reporting system to improve health care quality.

147.19 (c) The commissioner is not authorized to select from or between competing alternate  
147.20 acceptable medical practices.

147.21 **EFFECTIVE DATE.** This section is effective October 1, 2025.

147.22 Sec. 18. Minnesota Statutes 2022, section 147A.08, is amended to read:

147.23 **147A.08 EXEMPTIONS.**

147.24 (a) This chapter does not apply to, control, prevent, or restrict the practice, service, or  
147.25 activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13); persons  
147.26 regulated under section 214.01, subdivision 2; or persons midlevel practitioners, nurses,  
147.27 or nurse-midwives as defined in section 144.1501, subdivision 1, paragraphs (i), (k), and  
147.28 (h).

147.29 (b) Nothing in this chapter shall be construed to require licensure of:

197.20 Subd. 6. **Enforcement.** The commissioner of labor and industry shall enforce this section.  
197.21 The commissioner of labor and industry may assess a fine of up to \$5,000 for each violation  
197.22 of this section.

197.23 Sec. 93. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

197.24 Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish  
197.25 an adverse health event reporting system designed to facilitate quality improvement in the  
197.26 health care system. The reporting system shall not be designed to punish errors by health  
197.27 care practitioners or health care facility employees.

197.28 (b) The reporting system shall consist of:

197.29 (1) mandatory reporting by facilities of 27 adverse health care events;

197.30 (2) mandatory reporting by facilities of whether the unit where an adverse event occurred  
197.31 was in compliance with the core staffing plan for the unit at the time of the adverse event;

198.1 (3) mandatory completion of a root cause analysis and a corrective action plan by the  
198.2 facility and reporting of the findings of the analysis and the plan to the commissioner or  
198.3 reporting of reasons for not taking corrective action;

198.4 ~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of  
198.5 systemic failure in the health care system and successful methods to correct these failures;

198.6 ~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system  
198.7 requirements; and

198.8 ~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and  
198.9 the public to maximize the use of the reporting system to improve health care quality.

198.10 (c) The commissioner is not authorized to select from or between competing alternate  
198.11 acceptable medical practices.

198.12 **EFFECTIVE DATE.** This section is effective October 1, 2025.

228.28 Sec. 129. Minnesota Statutes 2022, section 147A.08, is amended to read:

228.29 **147A.08 EXEMPTIONS.**

228.30 (a) This chapter does not apply to, control, prevent, or restrict the practice, service, or  
228.31 activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13); persons  
228.32 regulated under section 214.01, subdivision 2; or persons midlevel practitioners, nurses,  
229.1 or nurse-midwives as defined in section 144.1501, subdivision 1, paragraphs (i), (k), and  
229.2 (h).

229.3 (b) Nothing in this chapter shall be construed to require licensure of:

148.1 (1) a physician assistant student enrolled in a physician assistant educational program  
148.2 accredited by the Accreditation Review Commission on Education for the Physician Assistant  
148.3 or by its successor agency approved by the board;

148.4 (2) a physician assistant employed in the service of the federal government while  
148.5 performing duties incident to that employment; or

148.6 (3) technicians, other assistants, or employees of physicians who perform delegated  
148.7 tasks in the office of a physician but who do not identify themselves as a physician assistant.

148.8 Sec. 19. **BEST PRACTICES TOOLKIT DEVELOPMENT.**

148.9 The commissioner of health must convene a stakeholder group that will meet for six  
148.10 months to develop a toolkit with best practices for implementation of workload committee  
148.11 and hospital staffing committees. The toolkit and best practices must include a  
148.12 recommendation that each hospital utilize a federal mediator or the Office of Collaboration  
148.13 and Dispute Resolution to moderate the establishment of committees in each hospital. The  
148.14 commissioner must make the toolkit with the recommended best practices available to  
148.15 hospitals by July 1, 2024.

148.16 Sec. 20. **DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT OF**  
148.17 **ANALYTICAL TOOLS.**

148.18 (a) The commissioner of health, in consultation with the Minnesota Nurses Association  
148.19 and other professional nursing organizations, must develop a means of analyzing available  
148.20 adverse event data, available staffing data, and available data from concern for safe staffing  
148.21 forms to examine potential causal links between adverse events and understaffing.

148.22 (b) The commissioner must develop an initial means of conducting the analysis described  
148.23 in paragraph (a) by January 1, 2025, and publish a public report on the commissioner's  
148.24 initial findings by January 1, 2026.

148.25 (c) By January 1, 2024, the commissioner must submit to the chairs and ranking minority  
148.26 members of the house and senate committees with jurisdiction over the regulation of hospitals  
148.27 a report on the available data, potential sources of additional useful data, and any additional  
148.28 statutory authority the commissioner requires to collect additional useful information from  
148.29 hospitals.

148.30 **EFFECTIVE DATE.** This section is effective August 1, 2023.

149.1 Sec. 21. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING**  
149.2 **WORKFORCE REPORT.**

149.3 (a) The commissioner of health must publish a public report on the current status of the  
149.4 state's nursing workforce employed by hospitals. In preparing the report, the commissioner  
149.5 shall utilize information collected in collaboration with the Board of Nursing as directed  
149.6 under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active  
149.7 licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals;

229.4 (1) a physician assistant student enrolled in a physician assistant educational program  
229.5 accredited by the Accreditation Review Commission on Education for the Physician Assistant  
229.6 or by its successor agency approved by the board;

229.7 (2) a physician assistant employed in the service of the federal government while  
229.8 performing duties incident to that employment; or

229.9 (3) technicians, other assistants, or employees of physicians who perform delegated  
229.10 tasks in the office of a physician but who do not identify themselves as a physician assistant.

271.29 Sec. 184. **DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT**  
271.30 **OF ANALYTICAL TOOLS.**

271.31 (a) The commissioner of health, in consultation with the Minnesota Nurses Association  
271.32 and other professional nursing organizations, must develop a means of analyzing available  
272.1 adverse event data, available staffing data, and available data from concern for safe staffing  
272.2 forms to examine potential causal links between adverse events and understaffing.

272.3 (b) The commissioner must develop an initial means of conducting the analysis described  
272.4 in paragraph (a) by January 1, 2025, and publish a public report on the commissioner's  
272.5 initial findings by January 1, 2026.

272.6 (c) By January 1, 2024, the commissioner must submit to the chairs and ranking minority  
272.7 members of the house and senate committees with jurisdiction over the regulation of hospitals  
272.8 a report on the available data, potential sources of additional useful data, and any additional  
272.9 statutory authority the commissioner requires to collect additional useful information from  
272.10 hospitals.

272.11 **EFFECTIVE DATE.** This section is effective August 1, 2023.

272.12 Sec. 185. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING**  
272.13 **WORKFORCE REPORT.**

272.14 (a) The commissioner of health must publish a public report on the current status of the  
272.15 state's nursing workforce employed by hospitals. In preparing the report, the commissioner  
272.16 shall utilize information collected in collaboration with the Board of Nursing as directed  
272.17 under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active  
272.18 licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals;

149.8 information collected and shared by the Minnesota Hospital Association on retention by  
149.9 hospitals of licensed nurses; information collected through an independent study on reasons  
149.10 licensed nurses are choosing not to renew their licenses and leaving the profession; and  
149.11 other publicly available data the commissioner deems useful.

149.12 (b) The commissioner must publish the report by January 1, 2026.

149.13 Sec. 22. **DIRECTION TO COMMISSIONER OF HEALTH; KEEPING NURSES**  
149.14 **AT THE BEDSIDE ACT IMPACT EVALUATION.**

149.15 By October 1, 2023, the commissioner of health must contract with the commissioner  
149.16 of management and budget for the services of the Impact Evaluation Unit to design and  
149.17 implement a rigorous causal impact evaluation using time-series data or other evaluation  
149.18 methods as determined by the Impact Evaluation Unit to estimate the causal impact of the  
149.19 implementation of Minnesota Statutes, sections 144.7051 to 144.7059, on patient care, nurse  
149.20 job satisfaction, nurse retention, and other outcomes as determined by the commissioner  
149.21 and the Impact Evaluation Unit. The Impact Evaluation Unit may subcontract with other  
149.22 research organizations to assist with the design or implementation of the impact evaluation.  
149.23 The commissioner of management and budget may obtain any relevant data from any state  
149.24 agency necessary to conduct this evaluation under Minnesota Statutes, section 15.08. By  
149.25 February 15, 2024, the commissioner of health must submit to the chairs and ranking minority  
149.26 members of the legislative committees with jurisdiction over health finance and policy draft  
149.27 legislation specifying any additional authorities the commissioner and the Impact Evaluation  
149.28 Unit may require to collect the data required to conduct a successful impact evaluation of  
149.29 the implementation of Minnesota Statutes, sections 144.7051 to 144.7059. By October 1,  
149.30 2024, the Impact Evaluation Unit must begin collecting baseline data. By June 30, 2029,  
149.31 the Impact Evaluation Unit must submit to the commissioner of health a public initial report  
149.32 on the status of the evaluation project and any preliminary results.

150.1 Sec. 23. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES.**

150.2 The commissioner of human services must define as a direct educational expense the  
150.3 reasonable child care costs incurred by a nursing facility employee scholarship recipient  
150.4 while the recipient is receiving a wage from the scholarship sponsoring facility, provided  
150.5 the scholarship recipient is making reasonable progress, as defined by the commissioner.  
150.6 toward the educational goal for which the scholarship was granted.

150.7 Sec. 24. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**  
150.8 **BEDSIDE ACT.**

150.9 (a) By October 1, 2024, each hospital must establish and convene a hospital nurse staffing  
150.10 committee as described under Minnesota Statutes, section 144.7053, and a hospital nurse  
150.11 workload committee as described under Minnesota Statutes, section 144.7054.

272.19 information collected and shared by the Minnesota Hospital Association on retention by  
272.20 hospitals of licensed nurses; information collected through an independent study on reasons  
272.21 licensed nurses are choosing not to renew their licenses and leaving the profession; and  
272.22 other publicly available data the commissioner deems useful.

272.23 (b) The commissioner must publish the report by January 1, 2026.

280.3 Sec. 189. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**  
280.4 **BEDSIDE ACT.**

280.5 (a) By October 1, 2024, each hospital must establish and convene a hospital nurse staffing  
280.6 committee as described under Minnesota Statutes, section 144.7053, and a hospital nurse  
280.7 workload committee as described under Minnesota Statutes, section 144.7054.

150.12 (b) By October 1, 2025, each hospital must implement core staffing plans developed by  
150.13 its hospital nurse staffing committee and satisfy the plan posting requirements under  
150.14 Minnesota Statutes, section 144.7056.

150.15 (c) By October 1, 2025, each hospital must submit to the commissioner of health core  
150.16 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

150.17 (d) By October 1, 2025, the commissioner of health must develop a standard concern  
150.18 for safe staffing form and provide an electronic means of submitting the form to the relevant  
150.19 hospital nurse staffing committee. The commissioner must base the form on the existing  
150.20 concern for safe staffing form maintained by the Minnesota Nurses' Association.

150.21 (e) By January 1, 2026, the commissioner of health must provide electronic access to  
150.22 the uniform format or standard form for nurse staffing reporting described under Minnesota  
150.23 Statutes, section 144.7057, subdivision 4.

150.24 Sec. 25. **REVISOR INSTRUCTION.**

150.25 In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b) to  
150.26 (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.  
150.27 The revisor shall make any necessary changes to sentence structure for this renumbering  
150.28 while preserving the meaning of the text. The revisor shall also make necessary  
150.29 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the  
150.30 renumbering.

280.8 (b) By October 1, 2025, each hospital must implement core staffing plans developed by  
280.9 its hospital nurse staffing committee and satisfy the plan posting requirements under  
280.10 Minnesota Statutes, section 144.7056.

280.11 (c) By October 1, 2025, each hospital must submit to the commissioner of health core  
280.12 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

280.13 (d) By October 1, 2025, the commissioner of health must develop a standard concern  
280.14 for safe staffing form and provide an electronic means of submitting the form to the relevant  
280.15 hospital nurse staffing committee. The commissioner must base the form on the existing  
280.16 concern for safe staffing form maintained by the Minnesota Nurses' Association.

280.17 (e) By January 1, 2026, the commissioner of health must provide electronic access to  
280.18 the uniform format or standard form for nurse staffing reporting described under Minnesota  
280.19 Statutes, section 144.7057, subdivision 4.

296.18 Sec. 202. **REVISOR INSTRUCTION.**

296.24 (c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b)  
296.25 to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.  
296.26 The revisor shall make any necessary changes to sentence structure for this renumbering  
296.27 while preserving the meaning of the text. The revisor shall also make necessary  
296.28 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the  
296.29 renumbering.